Witness Name: Christine Braithwaite
Statement No.: WITN7523001
Exhibits: WITN7523002-7523011
Dated: 16 November 2022

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF CHRISTINE BRAITHWAITE, DIRECTOR OF STANDARDS AND POLICY, PROFESSIONAL STANDARDS AUTHORITY FOR HEALTH AND SOCIAL CARE

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 16 April 2021.

I, Christine Braithwaite, will say as follows:

Section 1: Introduction

1. **Please set out your name, address, date of birth and any relevant professional qualifications relevant to the role you currently discharge.**

1. Name: Christine Braithwaite
   Address: Professional Standards Authority, 153-197 Buckingham Palace Road, London SW1W 9SP
   Date of Birth: GRO-C 1958
   Professional qualifications relevant to the role you currently discharge: LLM

2. **Please set out your membership, past or present, of any committees, associations, parties, societies or groups relevant to the Inquiry's Terms of Reference, including the dates of your membership and the nature of your involvement.**
2. Nil.

3. **Please confirm whether you have provided evidence to, or have been involved in, any other inquiries, investigations or criminal or civil litigation in relation to human immunodeficiency virus ("HIV") and/or hepatitis B virus ("HBV") and/or hepatitis C virus ("HCV") infections and/or variant Creutzfeldt-Jakob disease ("vCJD") in blood and/or blood products. Please provide details of your involvement and copies of any statements or reports which you provided.**
3. Nil.

Section 2:

4. **Please explain with reference to the report "Safer care for all. Solutions from professional regulation and beyond" (Document RLIT0001837):**
   a. what led to the recommendation that each UK country should have a Health and Social Care Safety Commissioner, or equivalent function;
   b. what would the role of the Health and Social Care Safety Commissioner or equivalent be;
   c. would the recommendation that each UK country should have a Health and Social Care Safety Commissioner affect the English Patient Safety Commissioner's role;
   d. how would the Commissioners work together, including the role of the proposed Consortium of UK Safety Commissioners?

4. *N.B. The below for the most part summarises and/or paraphrases what is in our report* Safer care for all. *Post-publication, however, we are continuing to develop our thinking, including how it relates to the issues examined by the Infected Blood Inquiry. Therefore, in this submission, there are both minor differences in wording from that in the report, and new material.*

5. *Our proposals remain at a relatively high level, because we have not yet completed our engagement with stakeholders to gain their views on our proposals and explore options in detail. There are different ways in which they could be implemented. We have therefore not sought to go into too much detail at this stage, when the proposals have yet to be fully developed, tested and consulted upon.*

6. *The positions set out in this statement represent the views of the Professional Standards Authority at the time of drafting.*

4.a What led to the recommendation that each UK country should have a Health and Social Care Safety Commissioner, or equivalent function?

7. My view is that Health and Social Care Safety Commissioners should be able to address many of the systemic difficulties that arise from the fragmented health and social care safety landscape.

8. The year 2022 marks twenty years since the inception of the Professional Standards Authority for Health and Social Care (the Authority). It was set up in 2003 under the National Health Service and Healthcare Professions Act 2002[1] as the Council for the Regulation of Healthcare Professionals in the wake of the *Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1994.*[2] It was tasked with bringing greater coherence and a focus on the public interest to healthcare professional regulation.

9. Our report, *Safer care for all*[3], published on 6 September 2022, is the product of the Authority's research and thinking about the role, potential and limits of professional regulation after two decades of statutory oversight, in furtherance of our objectives set out in the Act. We examined four big problems in health and social care to consider what more professional regulation could do to address them:

- the persistent inequalities felt by both users of care and professionals (*chapter 1, p22-35*)
- how regulation can keep pace with new ways of funding and delivering care (*chapter 2, p36-51*)
- the role of professional regulation in the workforce crisis (*chapter 3, p52-65)*

[1] See Part 3, Sections 25 to 29A, and Schedule 7 of the National Health Service and Healthcare Professions Act 2002. (**WITN7523011**)
[2] The Bristol Royal Infirmary Inquiry, July 2001. *The Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984–1995 Learning from Bristol.* (**RLIT0001343**)
[3] Professional Standards Authority for Health and Social Care, September 2022. *Safer care for all – solutions from professional regulation and beyond.* (**RLIT0001837**)

- balancing the need for individual accountability with the need for just cultures (*chapter 4, p66-81*).

10. The recommendation for a Health and Social Care Safety Commissioner *(chapter 5, p82-88)* emerges from one key observation, which itself relates to conclusions we draw in the previous chapters: **that the health and social care safety system is made up of a complex jigsaw of institutions, each with a specific remit, and no single body is tasked with ensuring that together they create an effective safety system that protects patients and service users.**

11. We believe that the following problems could be addressed, at least in part, by having a single body responsible for overseeing the safety system:

- Limited effectiveness of reviews and inquiries, both individually and collectively, stemming from the lack of a coherent national approach to dealing with major failings in health and social care, including:[4]
    - whether to inquire into major failings at all, and whether through a review, non-statutory public inquiry, or statutory inquiry
    - the scope of inquiries/reviews (e.g. the extent to which the actions of regulators are examined)
    - the implementation of recommendations.
- Harm and risk of harm going unaddressed because:
    - patients and service users are not listened to
    - data is not collected
    - information/ intelligence/ data is held in the wrong place and/or not shared with the appropriate bodies
    - the extent of a risk is not identified because bodies are not pooling their intelligence/data
    - trends that can only be spotted by taking a bird's-eye view are not identified

[4] See reports such as the Institute for Government (**WITN7523003**) and the House of Commons Library (see here: (**WITN7523010**)

- a joined-up response is required but none is forthcoming as a result of remit apathy ('not my responsibility') and/or lack of accountability for joint working.

- Persistent inequalities in health and social care outcomes affecting groups with characteristics protected under equalities legislation, as well as other characteristics such as rurality or socioeconomic status.

12. We have noted in the course of our work that once a review or inquiry is complete, usually after publication, that the secretariat tends to be disbanded. The publication of an inquiry's findings, conclusions and recommendations can bring to light information that others may need to act on. In particular, professional regulators may want to obtain information to help them identify people described anonymously in a report, if there is evidence that calls into question their conduct or competence. This becomes challenging if an review/inquiry team is no longer operational. An example of this is the review into failings at Shrewsbury and Telford Maternity Services which reported earlier this year.[5]

13. A practical difficulty identified by the Institute for Government's research into the effectiveness of inquiries, is that each inquiry must be set up from scratch, often at speed.[6] This task requires specific skills and experience, and according to the Institute, the current 'lack of guidance creates inefficiencies in the process of setting up an inquiry, and means that secretariats are not always able to access the full range of good practice.'[7]

14. Since we published *Safer care for all*, the Kirkup review into failings at East Kent Hospitals Maternity Services has reported,[8] and made observations about the apparent lack of effectiveness of inquiries about individual NHS trusts in stimulating system-wide improvement:

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[5] Donna Ockenden, March 2022. *Findings, conclusions and essential actions from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust.* (**WITN7523009**)
[6] Institute for Government, December 2017. *How public inquiries can lead to change.* (**WITN7523003**)
[7] Ibid, p20,
[8] Dr Bill Kirkup CBE, October 2022. Reading the signals - Maternity and neonatal services in East Kent – the Report of the Independent Investigation. (**WITN7523008**)

'The pattern is now sadly familiar: detailed investigation, lengthy reports, earnest and well-intentioned recommendations – all part of a collective conviction that this must be the last such moment of failure, with the lessons leading to improvement, not just locally but nationally. Experience shows that the aspirations are not matched by sustained improvement. Significant harm then follows, with almost always patients and families the first to raise the alarm. […] The answer cannot be to hope that individual reviews and multiple recommendations prevent recurrences elsewhere. If that approach were the right one, it would have worked by now. It hasn't.'[9]

15. We have observed that inquiries repeatedly identify similar failings, such as patients and families not being listened to (e.g. *Mid-Staffs,*[10] *Cumberlege*[11], *Morecambe Bay*[12]), lack of candour with patients and families (*e.g. Bristol,*[13] *Mid-Staffs,*[14] *Morecambe Bay*[15], *Cumberlege*[16]), and information that could have prevented further harm not being shared or acted upon (*e.g. Paterson,*[17] *Cumberlege,*[18] *Shrewsbury and Telford*[19]). It would be an important function of the Commissioner to have oversight of the implementation of review and inquiry recommendations.

16. We have noted the Infected Blood Inquiry's ("the Inquiry") interest in the question of how decisions are made about whether to establish a statutory

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[9] Dr Bill Kirkup CBE, October 2022. *Reading the signals - Maternity and neonatal services in East Kent – the Report of the Independent Investigation.* (**WITN7523008**) Para 1.129, p19.
[10] The Mid Staffordshire NHS Foundation Trust Public Inquiry, February 2013. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.* (**RLIT0001757**)
[11] Independent Medicines and Medical Devices Safety Review, July 2020. *First Do No Harm -The report of the Independent Medicines and Medical Devices Safety Review.* (**RLIT0001379**)
[12] Dr Bill Kirkup CBE, March 2015. *The Report of the Morecambe Bay Investigation.* (**WITN7523007**)
[13] The Bristol Royal Infirmary Inquiry, July 2001. *The Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984–1995 Learning from Bristol.* (**RLIT0001343**)
[14] The Mid Staffordshire NHS Foundation Trust Public Inquiry, February 2013. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.* (**RLIT0001757**)
[15] Dr Bill Kirkup CBE, March 2015. *The Report of the Morecambe Bay Investigation.* (**WITN7523007**)
[16] Independent Medicines and Medical Devices Safety Review, July 2020. *First Do No Harm -The report of the Independent Medicines and Medical Devices Safety Review.* (**RLIT0001379**)
[17] The Independent Inquiry into the issues raised by Paterson, February 2020. *Report of the Independent Inquiry into the Issues raised by Paterson.* (**WITN7523006**)
[18] Independent Medicines and Medical Devices Safety Review, July 2020. *First Do No Harm -The report of the Independent Medicines and Medical Devices Safety Review.* (**RLIT0001379**)
[19] Donna Ockenden, March 2022. *Findings, conclusions and essential actions from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust.* (**WITN7523009**)

inquiry.[20]. We think that the approaches and decisions taken by governments across the UK in response to major failings in health and care would benefit from greater coherence and believe that our Commissioner proposal could help to address this.

17. From the Inquiry's Terms of Reference, we see that it is examining the question of missed opportunities to prevent or put a stop to harm caused by the use of infected blood and blood products. We would hope that the existence of a Health and Social Care Safety Commissioner would mean that known risks to the safety of patients would not be overlooked in future.

b. What would the role of the Health and Social Care Safety Commissioner or equivalent be?

18. We see the Commissioner as having an overarching role focussed on ensuring that the various bodies charged with protecting the public work together as an effective system, rather than as a collection of disparate institutions and activities. We have suggested that each country could have its own Commissioner to reflect the devolution arrangements for health and social care policy and funding. In order to fulfil its role effectively, the development and operation of the Commissioner role would need to be informed by the views and experiences of those using and working within health and care services.

Functions

19. *Safer care for all* sets out functions that the Commissioner might carry out. For ease of reference, we have matched these functions to the problems listed above that each would help to address:

Problem	**Function**
• Limited effectiveness of reviews and inquiries, both individually and	**The Inquiries Office[21] would:** • Coordinate inquiries and reviews into health and care failings to bring

[20] As evidenced by Issues 408 and 409 of the Infected Blood Inquiry's *List of Issues*, as accessed in (**INQY1000245**)

[21] This is what we refer to in *Safer care for all* (**RLIT0001837**) as the Inquiries Secretariat.

Problem	Function
collectively, stemming from the lack of a coherent national approach to dealing with major failings in health and social care, including: o whether to inquire into major failings at all, and whether through a review, non-statutory public inquiry, or statutory inquiry o the scope of inquiries/reviews (e.g. the extent to which the role of regulators is examined) o the implementation of recommendations o lack of continuity of service post-publication • Inefficiency of each inquiry secretariat having to be set up from scratch	greater coherence and objectivity to decisions about how to respond, and how to establish terms of reference • Follow-up on progress against inquiry recommendations • Act as a contact point after the publication of the report for further queries • Carry out meta-analyses of inquiry findings to identify trends (in the absence of a broader risk intelligence function) • Act as a permanent secretariat so that inquiries can be set up and run efficiently.
• Trends that can only be spotted by taking a bird's-eye view are not identified • The extent of a risk is not identified because bodies are not pooling their intelligence/data • Information/ intelligence/ data is held in the wrong place and/or not shared with the appropriate bodies • Inequalities persist in health and social care outcomes, affecting groups with characteristics protected under equalities legislation, as well as other characteristics such as rurality or socioeconomic status.	**The Risk Intelligence function would:** • Review risk data produced by other organisations to identify trends and risks either nationally or locally • Report specifically on any inequalities concerns arising from safety data • Carry out meta-analyses of inquiry findings to identify trends (could fall under Inquiries office if risk intelligence function not implemented)

Problem	Function
• Data is not collected • Information/ intelligence/ data is held in the wrong place and/or not shared with the appropriate bodies • A joined-up response is required but none is forthcoming because of remit apathy ('not my responsibility') and/or lack of accountability for joint working • Patients are not listened to.	**The Expertise function would:** • Make recommendations for addressing risks identified through the intelligence function • Identify gaps in the patient and service user safety landscape, and make recommendations for addressing them • Identify gaps in data collection and make recommendations for addressing them • Recommend ways in which data collection can be improved and harmonised across the sector • Signpost people making complaints to the correct organisation (and take notes of concerns as part of the intelligence function) *(System improvements recommended by the Expertise function could also help to address problems listed in the previous row, against the Intelligence function)*

20. There are two challenges to our proposals that we would like to address here:

A. that there will be little appetite for a new or different safety commissioner role following the recent creation of the Patient Safety Commissioner role in England[22] (*more on this under 4.c.*), and moves to establish a broader role for a Patient Safety Commissioner for Scotland[23]

B. that their remit may be too extensive to be workable.

21. With respect to point A, we have recommended that the three functions set out in the table are carried out by a single body, the Commissioner, both because we believe they are closely interlinked, and to avoid creating further information silos.

[22] The Medicines and Medical Devices Act 2022, Part 1. (**WITN7523002**)
[23] The Patient Safety Commissioner for Scotland Bill, as introduced. (**WITN7523005**)

22. However, mainly because of moves already in train in at least two countries of the UK to establish patient safety commissioners following the recommendations of the *Independent Medicines and Medical Devices Safety Review report*,[24] we are taking a pragmatic view of how this recommendation could be implemented.

23. We see the Inquiries Office function as one that could be implemented and established on its own. This function could have a significant positive impact on patient safety, even in the absence of the other parts of the recommendation. Having one for each country would reflect the devolved responsibilities for health and care, and the fact that the Inquiries Act 2005 allows for both UK-wide and devolved inquiries.

24. If implemented on its own, the Inquiries Office might also take on the role of carrying out meta-analyses of review/inquiry findings and recommendations to identify trends, and checking up on the implementation of inquiry recommendations.

25. As regards point B, the most important aspects of our proposal are, in our view, that:

- there should be an independent body looking at whether the patient and service user safety system is working effectively, and finding solutions where it isn't, and
- its remit should be broad to avoid creating further silos and organisational boundaries.

26. A key question that would need to be explored in further development of the role, is the extent to which the Commissioner would or indeed could operate by simply carrying out checks on the effectiveness of the system. Our preference would be for an organisation that was relatively small and agile, working smartly to piggy-back on, rather than duplicate the work, and information outputs of the bodies already within the safety system. However

[24] Independent Medicines and Medical Devices Safety Review, July 2020. *First Do No Harm -The report of the Independent Medicines and Medical Devices Safety Review*. (**RLIT0001379**)

this would presumably only be possible if key data were available, reliable, and in formats that can be analysed and shared, all in a timely manner.

27. We might therefore consider the implementation of the Commissioner in phases with an initial phase concentrating on first mapping, then improving the system's own capacity to identify risks and act on them. As the effectiveness of the patient safety system it was overseeing improved, it could scale back its own activities.

Governance

28. We do not have firm views on the governance of the Commissioners, save that they should be, as far as possible, independent of Government and of the safety systems they are overseeing. This would, we believe, ensure objectivity to decisions about how to respond to a major failing in health or care. While the decision to initiate a statutory inquiry would presumably still rest with Ministers as mandated by the Inquiries Act Section 1, (1)[25] it could be on the published advice of the Commissioner, which was itself based on published criteria.

29. This independence would also help to ensure that the focus on patient safety was not affected by the political cycle, and allow for some continuity of action during periods of political turmoil in any of the four countries.

30. The model set out for Scotland is of interest as it would be primarily accountable to Parliament and substantially independent.[26] We are also attracted to the proposal in this Bill for an advisory group with a patient majority, as this would embed the patient voice in the governance of the role.

Powers

31. We are not attracted to the idea of the Commissioners having enforcement powers. In line with the principles set out in our guidance on regulatory

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[25] (**RLIT0001910**)
[26] See Schedule 1, s. 3(1) and 5 of the *Patient Safety Commissioner for Scotland Bill* as introduced (**WITN7523005**)

policy-making, *Right-touch regulation*,[27] we would advocate using the minimum regulatory force required to achieve the desired outcome.

32. Transparency can be a powerful tool, and for this type of role could be enough to effect change where needed. Again, with reference to the model proposed for Scotland, we note that the proposals in the draft Patient Safety Commissioner Bill[28] include publication powers for the Commissioner – to publish both the Commissioner's recommendation, and the response of the body to whom it was made, including a failure to comply.[29]

Funding

33. The Commissioner could either be funded by Government or by the bodies in the system it oversees, such as regulators, possibly also providers.

34. The Professional Standards Authority is funded by a statutory levy, which is approved by the Privy Council and paid for by the bodies it oversees, which gives us independence from Government. Our governance is independent of the regulators. The Commissioners could similarly be funded by the numerous organisations already involved in patient safety.

35. We acknowledge however that the question of funding for reviews and inquiries might need to be considered separately from that for the intelligence and expertise functions, given the significant costs of this work.

36. Overall, we would hope that over time, the preventative effects of each of the functions would ultimately lead to a reduction in costs to the public purse of safety incidents, by reducing their frequency and severity.

c. Would the recommendation that each UK country should have a Health and Social Care Safety Commissioner affect the English Patient Safety Commissioner's role?

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[27] Professional Standards Authority, 2015. *Right-touch regulation.* (**WITN7523004**)
[28] (**WITN7523005**)
[29] See sections 10 and 11 of the *Patient Safety Commissioner for Scotland Bill* as introduced. (**WITN7523005**)

37. Yes, it is likely to.

38. It is worth noting that the Cumberlege review, which originally recommended the creation of the patient safety commissioners, came to similar conclusions to the Authority on the need for a coordinating body:
'In our oral evidence sessions we asked the regulators and the arms-length bodies – both professional and systems regulators including the MHRA, NICE, CQC and NHS England and Improvement - and DHSC – if they could explain how what we had found in our Review had happened. They could not assist us. Each worked within the remit required of them. The linkages between them and the oversight of the system as a whole had not worked. Those we spoke to recognised the need for, and the complexities of achieving, a properly co-ordinated response but this had not been deliverable from within a fragmented healthcare system, despite numerous initiatives.'[30]

39. The role recommended by Baroness Cumberlege has many similarities with our own recommendation, albeit with the focus limited to medicines and medical devices:
'As an independent champion of the voice and experiences of patients and other members of the public on safety concerns, the Patient Safety Commissioner would have two aims: to improve identification of systemic safety issues and to improve the system's coordinated response. Through a renewed focus on patients' needs and a drive for cooperation and coordination, the Commissioner will help to release the wider benefits for the healthcare system from individual organisations' safety improvements.'[31]

40. The differences between what we are proposing and the English Patient Safety Commissioner relate primarily to the scope of the role:

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[30] Independent Medicines and Medical Devices Safety Review, July 2020. *First Do No Harm -The report of the Independent Medicines and Medical Devices Safety Review*. Para 2.128, p55-56. (**RLIT0001379**)
[31] Independent Medicines and Medical Devices Safety Review, July 2020. *First Do No Harm -The report of the Independent Medicines and Medical Devices Safety Review*. Appendix 2: The Patient Safety Commissioner, para 17, p205. (**RLIT0001379**)

- We believe that the Commissioner should span both health and social care, to reflect not only the longstanding government ambitions of greater integration of the two, but more importantly the reality of the experiences of people in receipt of care, for whom the distinction is artificial. The Commissioner in England does not cover social care, and neither would the Commissioner for Scotland, as currently defined in the Bill.
- If it were limited to healthcare, we believe the Commissioner's remit should not be restricted to just medicines and medical devices as is the case for England, and should instead cover all types of patient safety issue. In our view, the newly created role for England could in fact introduce more complexity by adding to the silos and organisational boundaries that we are seeking to overcome. There is also a risk that its remit is misunderstood by patients expecting it to be broader than just medicines and devices. In this respect, it appears that the proposals for a Commissioner for Scotland are more closely aligned with our Commissioner proposal than that introduced for England, because its remit would be patient safety generally, rather than just patient safety as it applies to medicines and medical devices
- Unlike the Patient Safety Commissioner for England, the proposal we make for a Commissioner would include a role coordinating responses to major failings, through an Inquiries Office (*more information is provided on this in the table above)*.

41. Politically, we appreciate that the timing of our recommendation is challenging, coming so soon after the legislation for the new English Commissioner. However, we hope that there could be scope for the role to evolve over time, particularly if, for example, the model offered in Scotland proved to be successful.

42. Alternatively, as set out in our answer to 4.b. above, we can see the merit in hiving off the Inquiries function, as we do not see this as necessarily integral to the broader safety role, and it could, even on its own, have a significant positive impact on the safety system.

d. How would the Commissioners work together, including the role of the proposed Consortium of UK Safety Commissioners?

43. I should note that we chose not to develop the Consortium proposal in any detail in *Safer care for all*, as we had not had the opportunity to engage with stakeholders or amass evidence to explore different options. In addition, the role and design of the Consortium might depend on how the Commissioner roles themselves were to develop, which adds to the complexity of the question. What follows is an explanation of why we made this recommendation, and some further exploration of what the Consortium might do to support the work of the individual Commissioners as well as adding value by, effectively, creating a UK-wide public safety endeavour.

44. We recommended the creation of a Consortium of UK Safety Commissioners, in the event that a Commissioner should be set up in each UK country, rather than for the whole of the UK. Our report identifies the risks of a fragmented system, and the need for more coherence, consistency, and better joint working. This thinking can also be applied at the level of the Commissioners themselves, and the Consortium proposal is our way of addressing these issues.

45. The value of having a Consortium would be in enabling close working between the Commissioners. Its aim would be to build a UK-wide picture of the effectiveness of the safety systems, and any significant threats to patient and service user safety, and work together with others to resolve them.

46. Beneath this aim, the Consortium could fulfil the following roles:

- standardise, as far as is possible or desirable, the Commissioner roles
- standardise, as far as is possible and desirable, the approach to reviews and inquiries
- encourage the standardisation of each country's mechanisms for reporting on key risk data, to improve comparability and UK-wide trend reporting
- share and compare data to report on UK-wide trends, or evidence of a significant risk

- compare reports on the effectiveness of the safety systems
- share examples of good and poor safety practices to enable UK-wide learning and develop UK-wide solutions
- Where appropriate, work together on specific projects
- represent the UK Health and Social Care Safety Commissioners internationally.

47. There are of course options for how this Consortium could be constituted – for example on a statutory basis or more informally; as an organisation, or as a conglomeration of the four Commissioners. For reasons set out above, we do not yet have a settled view on these points.

48. If implemented separately, the four Inquiries Offices would nonetheless need to cooperate closely, for the set-up of UK-wide inquiries. This would also mean that the benefits of a standardised approach in responding to major failings in health and care could be applied across the UK.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed GRO-C

Dated 12 December 2022

Table of exhibits:

Date	Notes/ Description	Exhibit number
2002	Safer care for all: Report 2002	RLIT0001837
2002	National Health Service Reform and Healthcare Professions Act 2002	WITN7523011
2002	Public Inquiry into children's heart surgery at the Bristol Royal Infirmary	RLIT0001343
December 2017	Institute for Government: How public inquiries can lead to change	WITN7523003
2005	House of commons library - Statutory Public Inquiries: the Inquiries Act 2005	WITN7523010
March 2022	Findings, conclusions and essential actions from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust. The Ockenden Report.	WITN7523009
2022	Reading the signals - Maternity and neonatal services in East Kent – the Report of the Independent Investigation 2022	WITN7523008
February 2013	The Mid Staffordshire NHS Foundation Trust Public Inquiry. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.	RLIT0001757
July 2020	Independent Medicines and Medical Devices Safety Review. First Do No Harm -The report of the Independent Medicines and Medical Devices Safety Review.	RLIT0001379
March 2015	Dr Bill Kirkup CBE. The Report of the Morecambe Bay Investigation.	WITN7523007
February 2020	The Independent Inquiry into the issues raised by Paterson. Report of the Independent Inquiry into the Issues raised by Paterson.	WITN7523006
23/09/2023	Baroness Dawn Primarolo's Witness Evidence	INQY1000245
2021	The Medicines and Medical Devices Act 2021	WITN7523002
2022	The Patient Safety Commissioner for Scotland Bill, as introduced.	WITN7523005
2005	The Inquiries Act 2005	RLIT0001910
2015	Professional Standards Authority, 2015. Right-touch regulation.	WITN7523004