Witness Name: Mr Rob Behrens
Statement No.: WITN7706001
Exhibits: WITN7706002
Dated: 7 September 2023

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF MR ROB BEHRENS ON BEHALF OF THE PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN

I provide this statement in response to a request under Rule 9(1) and (2) of the Inquiry Rules 2006 dated 31 July 2023.

I, Rob Behrens, will say as follows: -

Section 1: Response to Evidence

1. Please set out your name, address, date of birth and any professional qualifications relevant to the duties you discharge in the Parliamentary and Health Service Ombudsman.

1. Name: Rob Behrens
   Address: Parliamentary and Health Service Ombudsman, Citygate, Mosley Street, Manchester, M2 3HQ
   Date of birth: GRO-C 1952
   Professional qualifications relevant to the duties you discharge in the Parliamentary and Health Service Ombudsman:

   - BA (Hons), University of Nottingham
   - MA, University of Exeter

- Honorary Doctorates, University of Worcester, and Coventry University
- Vice President of the International Ombudsman Institute Europe
- Former Chair and Honorary life member of the European Network of Ombuds in Higher Education

2. Please provide a brief outline of the role and responsibilities of the Parliamentary and Health Service Ombudsman.

2. The Parliamentary and Health Service Ombudsman (PHSO) makes final decisions on complaints that have not been resolved by UK Government departments, the NHS in England and some other UK public organisations.

3. In holding public bodies to account, PHSO is impartial and independent of Government and the NHS in England. PHSO is not a regulator, a consumer champion or an advocacy service.

4. PHSO looks into complaints where an individual or group believes there has been injustice or hardship because an organisation has not acted properly or fairly or when it has provided a poor service and not put things right.

5. People should complain to the organisation first, so it has a chance to put things right. If an individual believes there is still a dispute about the complaint after an organisation has responded, they can ask PHSO to consider it.

6. PHSO shares findings from its casework with Parliament to help it hold to account organisations that provide public services. Findings and recommendations are shared more widely to support improvement. PHSO is accountable to Parliament and is scrutinised by the Public Administration and Constitutional Affairs Committee.

3. Mr Bragg proposes that there should be a statutory responsibility for all employees in the NHS to make a report when serious injury or death has occurred which might have been preventable, and that there should be a new, single organisation with responsibility to collect such information, to investigate incidents and to make sure that effective action has been taken. Please set out your response, from the perspective of the Parliamentary and Health Service Ombudsman, to this proposal. Please provide any further comments regarding Mr. Bragg's proposals that you wish to provide.

7. I am very sorry to hear about Mr Bragg's experiences as a harmed patient who has been let down by the system. I value Mr Bragg's perspective and I am regretful that it has taken many years for Mr Bragg's to find answers and get justice. Failings in medical care need to be recognised and addressed, and action must be taken to make sure they do not happen again.

8. It is essential that NHS organisations and individual NHS staff are open and honest when patients suffer harm from failings in their care. Only then can the NHS learn from its failings and patients, families and carers have trust in the accountability and transparency of the service. Unfortunately, in many of the complaints that PHSO investigates, findings show that NHS organisations have not been open, transparent, or accountable.

9. In June 2023, PHSO published *Broken trust: Making patient safety more than just a promise* [WITN7706002]. This major report shared findings of qualitative analysis of over 400 NHS investigations PHSO closed over the past three years. The report identifies 22 cases where PHSO found that a death was — more likely that not — avoidable.

10. PHSO also found that the physical harm patients experienced was too often compounded by inadequate, defensive and insensitive responses from NHS organisations when patients and their families raised concerns.

11. When looking at the direct causes of patient harm in the complaints investigated, PHSO identified four broad themes of clinical failings leading to avoidable death:

- failure to make the right diagnosis
- delays in providing treatment
- poor handovers between clinicians
- failure to listen to the concerns of patients or their families.

12. PHSO also identified a number of features that compounded harm for grieving families when they sought answers about what had happened, but were met with a poor response from NHS organisations:

- a failure to be honest when things go wrong
- a lack of support to navigate complex systems, such as complaints, investigations and inquests
- poor quality investigations
- a failure to respond to complaints in a timely and compassionate way
- inadequate apologies
- unsatisfactory learning responses.

13. The report sets out recommendations to improve patient safety. These include:

- better support for families affected by harm
- embedding cultures that promote honesty and learning from mistakes
- getting the right oversight and regulatory structures to prioritise patient safety
- an evidence-based and long-term workforce strategy that has cross-party support.

14. In relation to Mr Bragg's proposal for a new statutory duty, my view is that there are already substantive legal and professional duties in place to be open and honest about patient safety incidents. For example, doctors are bound by the duties set out in the General Medical Council's (GMC) Good Medical Practice. Nurses, midwives and nursing associates are bound by the Nursing and Midwifery Council's (NMC) Code. These include obligations to be open

and honest with employers and investigations and to report any concerns which put safety at risk.

15. In addition, the statutory duty of candour was introduced in 2014 in regulations under the Health and Social Care Act 2008. Regulation 20 puts a legal duty on health and social care providers to be open and transparent with people using services and with their families. It sets out actions that providers must take when 'a notifiable safety incident' occurs. This includes telling the relevant person what has happened, saying sorry, explaining what further inquiries or investigations will take place and keeping secure records of all meetings and communications.

16. However, from a number of the cases PHSO analysed for the *Broken Trust* report [WITN7706002], it is evident that duty of candour is not always implemented as it should be. For example, in a case where a baby died after antibiotics were not given quickly enough, PHSO found that important details about the sequence of events and the nature of the infection were not given to the parents until seven weeks after their son died. Staff even discussed deleting a recording made during a meeting when the parents temporarily stepped out of the room because they realised what they had said might get the Trust into difficulty.

17. It is clear that almost a decade on from its introduction, the statutory duty of candour requires further examination in order to be effective. In *Broken Trust*, PHSO recommends that the Department of Health and Social Care (DHSC) and NHS England should further scrutinise the lack of compliance with the duty of candour. It should carry out a review to assess its effectiveness, taking account of whether changes to the duty itself are required to ensure that NHS employees are sufficiently open and transparent about avoidable harm.

18. It is not enough to have the right policies in place – we need to establish that they are working effectively on the frontline. Any renewed or updated duty should therefore be assessed for effectiveness within 2-3 years of its implementation.

19. In my view, the culture in which clinicians are operating can be just as important as the legal duties placed upon them. Defensive cultures are a product of defensive leadership, so the behaviour of senior leaders is critical in creating an open, transparent environment where patient safety is prioritised.

20. The principle of honesty when things go wrong is crucial not just for the health service but for public services in general. The learning from the DHSC's review of duty of candour should also inform plans for a Public Authorities and Accountability Bill, which is calling for an expansion of duty of candour to all public services.

21. In relation to Mr Bragg's proposal around the creation of a single organisation with responsibility to collect information, investigate incidents and to make sure that effective action has been taken, I am strongly of the view that this will not solve the current issues we face.

22. A complex regulatory landscape already exists within healthcare, undermining accountability and making access to justice more difficult for people using the NHS. I recognise that Mr Bragg's proposal to create a single organisation to collect data, investigate incidents, and monitor the learning aims to overcome this complexity. While I support the intention, I am firmly of the view that creating another new oversight body would add further complexity and inefficiency.

23. At present there are over a dozen different health and care regulators all playing varied but important roles in patient safety. A number of organisations carry out the function of investigating NHS care, including but not limited to local organisations, the Healthcare Safety Investigation Branch (HSIB), the Care Quality Commission (CQC) and NHS Resolution. This landscape needs to be made clearer, not larger.

24. There is a need to streamline some of these functions for the benefit of people who use the NHS, their families and carers. We need a system that is coherent and easier to navigate, based on evidence and engagement with patients, families, NHS staff and leaders. As recommended in *Broken Trust,* DHSC should first commission an independent review of what an effective set of patient safety oversight bodies would look like. This review should also include considerations of restrictions which currently prevent the existing bodies from acting, and which if removed, could enable quicker and more effective action to be taken to ensure patient safety.

4. The Inquiry has obtained statements from Dr Benneyworth of the Healthcare Safety Investigation Branch, and Ms Braithwaite from the Professional Standards Authority for Health and Social Care, giving their views on Mr Bragg's proposal. To the extent not already addressed above, please set out your response, from the perspective of the Parliamentary and Health Service Ombudsman, to this suggestion.

25. The Professional Standards Authority (PSA) recommends the creation of a Health and Social Care Commissioner role for each country. I strongly agree with both the PSA and HSIB in their view that the current patient safety system is overcomplicated and fragmented. However, I do not believe that the solution lies in the creation of another body. As indicated above, DHSC should commission an independent review of what an effective set of patient safety oversight bodies would look like. The review must include meaningful engagement with NHS leaders, NHS staff, existing patient safety oversight bodies, patients and families.

26. DHSC must then act on the recommendations of its review to ensure that the oversight of patient safety is prioritised and that oversight bodies operate effectively as part of a clear and coherent system.

27. HSIB highlights the need for a much more structured approach to the development of a safety management system across the health and care

landscape. I support their ongoing work in this area and their findings that safety could be managed more effectively.

28. HSIB recommends that data relating to patient safety be aggregated to inform the identification of patient safety priorities. Dr Benneyworth states that aggregation of data should start at clinical service provider and integrated care board (ICB) level and then at regional and national levels. I support this recommendation. As outlined in *Broken Trust*, ICBs should play a key role in developing a clear view of emerging risks and issues within patient safety.

Statement of Truth

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

Signed

GRO-C

Dated 7 September 2023