Witness Name: Karl Banister
Statement No.: WITN7747001
Exhibits: WITN7747002
Dated: 1 March 2024

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF KARL BANISTER

I provide this statement in response to the request under Rule 9 of the Inquiry Rules 2006 dated 19 July 2023.

I, KARL BANISTER, will say as follows: -

Section 1: Introduction

1. Name: Karl Banister
2. Date of Birth: GRO-C 1970
3. Occupation: Director of Operations, Legal and Clinical at the Parliamentary and Health Service Ombudsman
4. Position Held Since: 1 January 2023

Section 2: Responses to criticism by Witness W7463

5. I have been provided with a witness statement of W7463. Whilst the majority of the statement relates to the care provided to W7463's father, it also addresses issues relating the subsequent complaint made to the Parliamentary and Health Service Ombudsman (PHSO) about that care and it is that which I predominately address.

The Role of PHSO

6. 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.

7. 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.

8. 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.

9. 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.

10. 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.

How PHSO Operates

11. In order to fulfil its role, PHSO employs a number of casework staff, supported by various other specialities, to investigate and make decisions on complaints brought to us, where appropriate. In addition to the underpinning legislation and caselaw, PHSO colleagues are assisted in this by comprehensive guidance on the process called ‘Service Model Guidance’ (SMG) which is available to the public on our website. This and associated specific guidance are updated as and when needed.

12. All caseworkers joining PHSO are given comprehensive training in our underpinning legislation and SMG, as well as other more general training applicable to PHSO. They are overseen by experienced Operations Managers and Assistant Directors. More experienced caseworkers also informally support and mentor new joiners, and there are also different forums for further support and guidance, as required.

The experience of W7463

13. I was very sorry to learn of W7463 and their family's bereavement. I understand that the complaint that was brought to PHSO was very important to them and that they were disappointed in the outcome.

Concerns about Bias

14. Having reviewed the case, I do not believe there was any bias in the decision made and I am sorry that this is what W7463 thinks occurred. I hope that by addressing this and providing some more information, I may be able to offer some reassurance.

15. At PHSO, we take diversity and inclusion very seriously. We also understand that unconscious bias exists. Our Equality and Diversity Team provide regular training on such matters, including Unconscious Bias, so we can make the best and fairest decisions possible.

16. There are also organisational safeguards in place to ensure we reach the right decision. All caseworkers have regular case discussions with their managers, who review the cases and sign off decisions. The managers also discuss difficult cases with each other and their Assistant Directors. Cases with challenging issues may be classified accordingly and additional oversight is offered on those cases. Very complex cases are overseen directly by the Ombudsman or a deputy.

17. At PHSO, there is an opportunity to comment on a decision before it is made. As well as sharing 'emerging thinking' throughout the life of the case, a formal

'Provisional View' is sent to all involved in advance and comments are invited. This enables all parties to look at what material has been considered and to see our provisional thinking in the form a final decision would take, so they can understand the evidence we have considered and how we propose to evaluate and consider it. If they think something has been misunderstood or if there is anything further they think PHSO should obtain they have an opportunity to say so and we will then consider the impact of those views before reaching our decision on the complaint. Sometimes this may mean sharing a further provisional view.

18. Once the final decision is made, there are still opportunities to address any issues. There is an internal review to the relevant manager in the first instance and, if appropriate, an escalation to the Ombudsman's Assurance Team. If that does not resolve any concerns, then ultimately it is possible to seek an external view from the Courts by way of Judicial Review.

19. This means that, in the unlikely event someone had made an error or, indeed, was biased in some way, there are multiple opportunities for this to be identified and addressed.

20. In this case, I can see that it was dealt with at all stages by an experienced caseworker and manager. In addition to the standard discussions throughout the case, a review was requested by the family as they did not agree with the decision. This was undertaken and it was felt that the decision was correct.

21. Whilst we understand that it is often disappointing when a complaint is not upheld, it is our aim that people are reassured that an independent person has looked at what happened and really considered it to ensure nothing did go wrong, so I am sorry the family in this case do not feel that here.

The complaints and regulatory landscape in health matters

22. W7463 raises concerns about the confusion about who should deal with complaints. At PHSO, we concur that the landscape of complaint handling and regulation is confusing and it is likely to assist all stakeholders – patients; the

public; healthcare professionals and the NHS more broadly – if such clarification could occur.

23. Accordingly, in June 2023, PHSO published a report (WITN7747002) which, amongst other things, called for the Department of Health and Social Care to commission a review of the matter to ascertain what an appropriate and effective framework of patient safety oversight organisations could look like.

Other Concerns about PHSO

24. I was sorry to read that W7463 does not think PHSO is fit for purpose. As Director of Operations, Legal and Clinical, I feel that PHSO deliver a good service to very many people every year. However, I accept that there are always improvements to be made and seek to foster an engaged and learning culture at all times. We are currently looking at how we can deliver as impactfully as possible and seeking views from many individuals and groups to enable this. I am very proud of this work and think it will provide real opportunities for PHSO to provide even better service.

25. Annually, the Ombudsman and senior leaders address PACAC about the work that PHSO do and, generally, it seems that PACAC agree that PHSO do deliver well and support our plans for ongoing improvement.

26. As I have noted above, I am sorry that W7463 did not get the outcome they were hoping for but am grateful they have shared their experience.

Section 3: Other Issues

27. I do not have any other issues to comment upon.

Statement of Truth

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

Signed

GRO-C

Dated 1 March 2024