2014 HOSPITAL AUTHORITY CONVENTION

*8 May 2014*

# Disclosure of Mistakes and Errors

*Robert Francis QC*

*Serjeants' Inn Chambers*
*85 Fleet Street*
*London EC4Y 1AE*

SERJEANTS' INN CHAMBERS

# A new broom arrives in the NHS

What is the regulatory and policy regime best placed to help the NHS do so? Some of the active ingredients are: **actively empower patients** so their needs and preferences continually reshape care delivery; **align incentives, information and decision rights with the frontline health professionals** who can best effect improvement; **remove barriers that block job redesign and new ways of working**; look sceptically at organisational monopolies created in the name of integration; prefer rapid experimentation, adaptive feedback loops, and emergent organisational configurations over one-size-fits all solutions from Whitehall; **stimulate pluralism** by ensuring level playing fields for new entrants**; strengthen scrutiny of clinical care,** and **introduce full public transparency on performance variation**; and ensure the overarching structure of health system regulation is fit-for-purpose.

Simon Stevens, *Living to be 500, death by asteroid and the inevitability of NHS Reform,* from *The Next Ten Years*, Reform, March 2012

# A consistent theme

- House of Commons Health Select Committee 6th report [2000]
  - *Doctors should tell relatives thee facts unless the patient has requested them not to do so*
- Bristol Royal Infirmary Inquiry Report 2001
  - *A duty of candour meaning a duty to tall a patient if adverse events have occurred, must be recognised as owed by all those working in the NHS to patients*
- Making Amends – CMO 2003
  - Recommended duty of candour + exemption from disciplinary action for those reporting
  - *Overall too many families are left with the impression that the NHS closes ranks when something goes wrong, to exclude the victim*

# The people who wanted answers to their questions…

… and would not rest until they got them…

# What happens in a culture without candour: A report on a whistleblower's complaint disappears

*The investigation has found evidence of poor leadership and management and of poor nursing care on Ward 3 … There is a strong view on the Ward that failings are due to the poor staffing levels and therefore excusable. The culture on the ward appears to allow for support of this view … Nobody at directorate/Trust level appears to have taken responsibility for monitoring/auditing to ensure that basic nursing standards/patient care needs are met … There appears to be a lack of commitment at the highest level in the Trust to tackle these problems*

*Barry report **August 2005**: Public Inquiry Report page 68*

# An internal lawyer's report remained internal and unknown

A detailed investigation has been undertaken including obtaining information from 14 members of staff and considering a substantial number of documents. The following problems have been identified:

- failure to control diabetes
- failure to administer prescribed drugs
- failure to undertake nursing handovers properly or at all
- failure to complete nursing records adequately or at all
- failure to conduct medical ward rounds properly
- failure to make adequate or proper notes of ward rounds and care plans
- failure to give the patient a diabetic menu
- failure to report this matter as a SUI in a timely fashion
- failure to report to report to the Coroner

*Extract from Trust investigation report into a death in April 2007*

# A Royal College report remained confidential

- Surgical Department dysfunctional and lacking effective leadership
- Colorectal department dysfunctional since 2003.
- No working relationship between surgeons in the team:

  *... no cohesion within the department ... makes it very difficult for other members of the team to function in a satisfactory way*
- Multidisciplinary team meetings compromised by disagreement;
- No departmental protocols on bowel preparation, antibiotic usage and postoperative management;
- Surgeon had little or no insight into the problems over 4 years

Extract from RCS report October 2007.

*Public Inquiry report page 111-112*

# Consequences for a nurse who spoke up…

*People saying that they know where I live, and basically threats to sort of my physical safety were made, to the point where …at the end of a shift … at night [I] would have to have either my mum or my dad or my husband come and collect me from work because I was too afraid to walk to my car in the dark on my own.*

*Evidence of Helene Donnelly MBE to the Mid-Staffordshire NHS Foundation Trust Public Inquiry*

… and for patients …

THE TIMES

**Ambulance driver abuses Mid Staffs Campaigner Julie Bailey on Facebook**

THE SUNDAY TIMES

**Hospital whistleblower hounded out of town**

" I hope you suffer a life-threatening illness at night where you have to travel further than you should do because your local hospital is closed (your fault)."

"Thank you for closing Stafford hospital, Ha, Ha, Ha, you better now spend more time watching your mother's grave."

# A case for candour...

- Ruptured spleen
- Not diagnosed by junior A&E doctor; discharged
- Death the following day
- Opinion of senior consultant in A&E:

*... as a result of my examination of the Doctor's medical notes I cannot find enough evidence which would lead me to conclude that a thorough abdominal examination was carried out on Mr Moore-Robinson on his attendance to the A&E department... I remain gravely concerned that Mr Moore-Robinson died from the effects of his accident on 1 April 2006. I would therefore raise the possibility that his unfortunate, untimely death may have been avoided, had he been more properly assessed on his initial attendance to the A&E department*

*Public Inquiry report page 184-185*

# Denial of candour – a case study

*With regards to the content of reports for the Coroner ... as reports are generally read out in full at the Inquest and the press and family will be present, with a view to avoiding further distress to the family and adverse publicity I would wish to avoid stressing possible failures on the part of the Trust ... In my opinion it is self evident from your report that that is probably the case but I feel such a concluding statement may add to the family's distress and is not one which I would wish to see quoted in the press*

Solicitor's request to consultant to change report: Public Inquiry Report page 185-186

# Reasons for not telling anyone…?

*"I have some concerns as to its content. Whilst it would be entirely appropriate as a report in respect of a clinical negligence claim it goes beyond the issues which concern the Coroner. The Coroner is undertaking a fact finding exercise and does not concern himself with matters of blame or potential negligence. I would therefore like to suggest that the section of your report headed "Conclusion" with the exception of the final para be removed."*

Solicitor's requests to consultant to change report: Public Inquiry Report page 185-186

# The effect

- The Coroner

  *It may have been helpful to have had [the consultant's] report prior to the Inquest … It is difficult to think back and wonder if this would have changed matters. I suspect I would have asked [the consultant] to give evidence at the Inquest but I would not have engaged an independent expert. I doubt very much however if this would have changed my conclusions*

- The Family

  *Having to struggle and cope with the death of our John is every parent's worst nightmare but discovering the events that followed with people in public office… withholding evidence from the Inquest and asking for reports to be altered is hard to bear*

  *I think it is absolutely despicable. I mean, these are legal people. That should never -- never happen. I just -- I can't -- it really -- it really upsets me and really aggravates me to think that.. that happened.*

*Public Inquiry Report page 187; Statement of Mrs Robinson para 553; Evidence of Mrs Robinson Day 10 page 2 closed session*

# Chief Executive's apology

Mid Staffordshire General Hospitals NHS
NHS Trust

Dear Mr and Mrs Robinson

**Re: John William Moore-Robinson**

I am writing personally to express my apologies and regret for the death of your son, which occurred shortly after his discharge from the A&E Department here at Staffordshire General Hospital.

I am pleased settlement of the claim has been agreed.

While I understand that nothing can compensate for the loss of a loved one, I hope the fact that matters have been resolved speedily will go some way to enable you to put this matter behind you and move on.

I would like to take this opportunity to pass my best wishes for the future to you.

Yours sincerely

**Martin Yeates**
**Chief Executive**

# Family's reaction

*We could not believe what we were reading. … "to enable you to put this matter behind you and move on", I don't know how on earth he thinks that we can possibly do that. I can never, ever, put John's death behind me. It will always be with me.*

# Openness, transparency & candour
# The principles

- Every healthcare organisation and everyone working for them, or on their behalf, must be honest, open and truthful in all dealings with patients and the public.
- Organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful.
- Where harm has been, or may have been, caused to a patient by an act or omission of the organisation or its staff, the patient should be informed of the incident, given full disclosure of the surrounding circumstances and be offered appropriate support.
- Full and truthful answers must given to any question reasonably asked by or for a patient about treatment.
- Any required statement to regulators or commissioners must be completely truthful and not misleading by omission.
- Any public statement made by a healthcare organisation about its performance must be truthful and not misleading by omission.

*Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry page 1491* [2013]

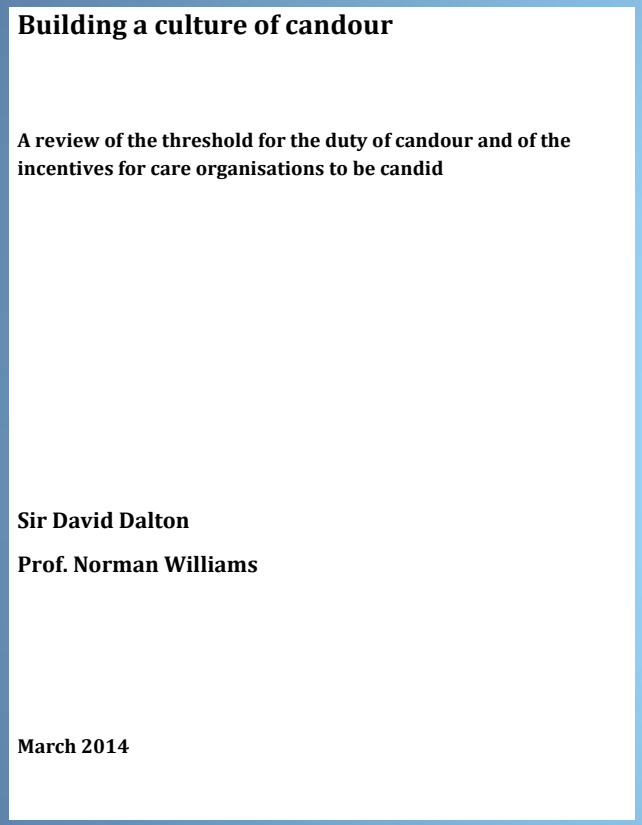
# Candour recommendations

- *Recommended statutory obligation*
  - Healthcare provider organisations under a duty to inform patient
  - Professionals under duty to tell the organisation
  - As soon as reasonably practicable
  - The provision of information in compliance with this requirement should not of itself be evidence or an admission of any civil or criminal liability, but non-compliance with the statutory duty should entitle the patient to a remedy
- *Recommended criminal offences for directors:*
  - Knowingly to obstruct another in the performance of these statutory duties;
  - To provide information to a patient or nearest relative intending to mislead them about such an incident;
  - Dishonestly to make an untruthful statement to a commissioner or regulator knowing or believing that it is likely to rely on the statement in the performance of its duties

# Government response

- Accepts “gagging” clauses should go
- Contractual & statutory duty of candour to patients for organisations
- Strengthening codes of conduct for professionals
- Legal sanctions on organisations for wilful misleading or withholding information from patients
- Breach of CQC regulations could be prosecuted

# Williams/Dalton review


**Building a culture of candour**

**A review of the threshold for the duty of candour and of the incentives for care organisations to be candid**

**Sir David Dalton**

**Prof. Norman Williams**

**March 2014**

- Threshold to be set at “significant” harm
- Staff training & support
- Improve reporting volume & accuracy
- Spread & apply lessons
- Sanctions to be “explored” in consultation

# Some challenges in practice

- The worried patient who seeks reassurance from the doctor at the bedside
- Uncertainties about cause and effect
- The trainee who has seen poor practice
- The management trainee who is told not to raise concerns with a non executive director
- The fear of incrimination – getting the balance right
- What is the right remedy?

# Some thoughts…

- Candour is intrinsic to doctor-patient partnership
- Partnerships require full cooperation and trust
- Partnerships require a joint approach to problems
- Adversarial process destroys relationships
- Patients want explanations, advice, help, corrective action, and learning
- Early honesty preserves relationships minimises the damage to patients,, staff and the organisation

2014 HOSPITAL AUTHORITY CONVENTION

*8 May 2014*

# Disclosure of Mistakes and Errors

*Robert Francis QC*

*Serjeants' Inn Chambers*
*85 Fleet Street*
*London EC4Y 1AE*

SERJEANTS' INN CHAMBERS