THE MID STAFFORDSHIRE
NHS FOUNDATION TRUST
PUBLIC INQUIRY

Chaired by Robert Francis QC

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

Executive summary

HC 947

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February 2013

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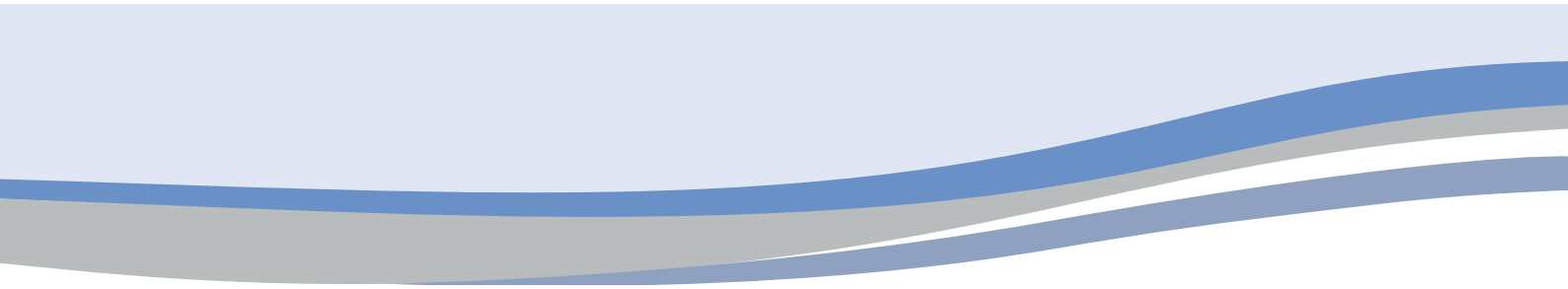

Letter to the Secretary of State

Mid Staffordshire NHS Foundation Trust Public Inquiry
Skipton House
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The Rt Hon Jeremy Hunt MP
Secretary of State for Health
Richmond House
79 Whitehall
London
SW1A 2NS

5 February 2013

Dear Secretary of State

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

As you know, I was appointed by your predecessor to chair a public inquiry under the Inquiries Act 2005 into the serious failings at the Mid Staffordshire NHS Foundation Trust. Under the Terms of Reference of the Inquiry, I now submit to you the final report.

Building on the report of the first inquiry, the story it tells is first and foremost of appalling suffering of many patients. This was primarily caused by a serious failure on the part of a provider Trust Board. It did not listen sufficiently to its patients and staff or ensure the correction of deficiencies brought to the Trust's attention. Above all, it failed to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities. This failure was in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care.

The story would be bad enough if it ended there, but it did not. The NHS system includes many checks and balances which should have prevented serious systemic failure of this sort. There were and are a plethora of agencies, scrutiny groups, commissioners, regulators and professional bodies, all of whom might have been expected by patients and the public to detect and do something effective to remedy non-compliance with acceptable standards of care. For years that did not occur, and even

after the start of the Healthcare Commission investigation, conducted because of the realisation that there was serious cause for concern, patients were, in my view, left at risk with inadequate intervention until after the completion of that investigation a year later. In short, a system which ought to have picked up and dealt with a deficiency of this scale failed in its primary duty to protect patients and maintain confidence in the healthcare system.

The report has identified numerous warning signs which cumulatively, or in some cases singly, could and should have alerted the system to the problems developing at the Trust. That they did not has a number of causes, among them:

- A culture focused on doing the system's business – not that of the patients;
- An institutional culture which ascribed more weight to positive information about the service than to information capable of implying cause for concern;
- Standards and methods of measuring compliance which did not focus on the effect of a service on patients;
- Too great a degree of tolerance of poor standards and of risk to patients;
- A failure of communication between the many agencies to share their knowledge of concerns;
- Assumptions that monitoring, performance management or intervention was the responsibility of someone else;
- A failure to tackle challenges to the building up of a positive culture, in nursing in particular but also within the medical profession;
- A failure to appreciate until recently the risk of disruptive loss of corporate memory and focus resulting from repeated, multi-level reorganisation.

I have made a great many recommendations, no single one of which is on its own the solution to the many concerns identified. The essential aims of what I have suggested are to:

- Foster a common culture shared by all in the service of putting the patient first;
- Develop a set of fundamental standards, easily understood and accepted by patients, the public and healthcare staff, the breach of which should not be tolerated;
- Provide professionally endorsed and evidence-based means of compliance with these fundamental standards which can be understood and adopted by the staff who have to provide the service;
- Ensure openness, transparency and candour throughout the system about matters of concern;
- Ensure that the relentless focus of the healthcare regulator is on policing compliance with these standards;
- Make all those who provide care for patients – individuals and organisations – properly accountable for what they do and to ensure that the public is protected from those not fit to provide such a service;

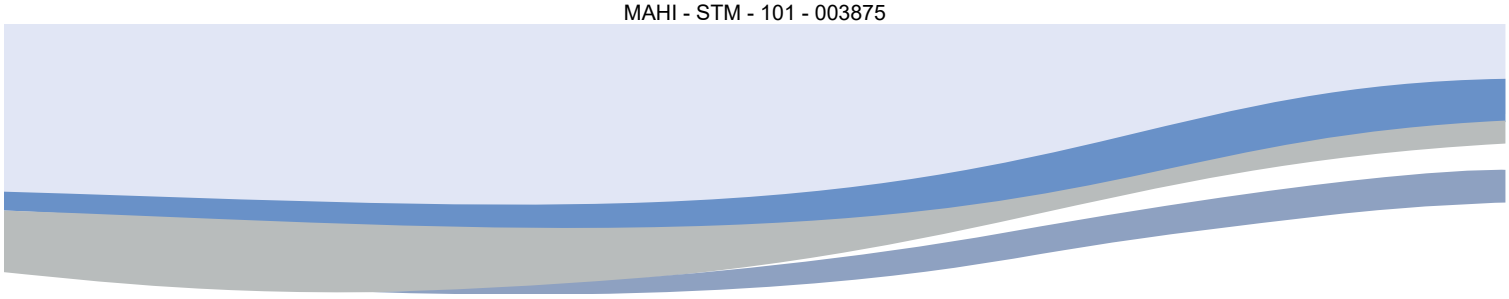
- Provide for a proper degree of accountability for senior managers and leaders to place all with responsibility for protecting the interests of patients on a level playing field;
- Enhance the recruitment, education, training and support of all the key contributors to the provision of healthcare, but in particular those in nursing and leadership positions, to integrate the essential shared values of the common culture into everything they do;
- Develop and share ever improving means of measuring and understanding the performance of individual professionals, teams, units and provider organisations for the patients, the public, and all other stakeholders in the system.

In introducing the first report, I said that it should be patients – not numbers – which counted. That remains my view. The demands for financial control, corporate governance, commissioning and regulatory systems are understandable and in many cases necessary. But it is not the system itself which will ensure that the patient is put first day in and day out. Any system should be capable of caring and delivering an acceptable level of care to each patient treated, but this report shows that this cannot be assumed to be happening.

The extent of the failure of the system shown in this report suggests that a fundamental culture change is needed. This does not require a root and branch reorganisation – the system has had many of those – but it requires changes which can largely be implemented within the system that has now been created by the new reforms. I hope that the recommendations in this report can contribute to that end and put patients where they are entitled to be – the first and foremost consideration of the system and everyone who works in it.

Yours sincerely

Robert Francis QC
Inquiry Chairman



Introduction

Background

1 Between 2005 and 2008 conditions of appalling care were able to flourish in the main hospital serving the people of Stafford and its surrounding area. During this period this hospital was managed by a Board which succeeded in leading its Trust[1] (the Mid Staffordshire General Hospital NHS Trust) to foundation trust (FT) status. The Board was one which had largely replaced its predecessor because of concerns about the then NHS Trust's performance. In preparation for its application for FT status, the Trust had been scrutinised by the local Strategic Health Authority (SHA) and the Department of Health (DH). Monitor (the independent regulator of NHS foundation trusts) had subjected it to assessment. It appeared largely compliant with the then applicable standards regulated by the Healthcare Commission (HCC). It had been rated by the NHS Litigation Authority (NHSLA) for its risk management. Local scrutiny committees and public involvement groups detected no systemic failings. In the end, the truth was uncovered in part by attention being paid to the true implications of its mortality rates, but mainly because of the persistent complaints made by a very determined group of patients and those close to them. This group wanted to know why they and their loved ones had been failed so badly.

2 The NHS is a service of which the country can be justly proud, offering as it does universal access to free medical care, often of the highest order. It is a service staffed by thousands of dedicated and committed staff and managers who have been shocked by what they heard of the events surrounding the Trust. It is inconceivable to many of them that conditions of the type described by so many patients can have been allowed to exist let alone persist. Those responsible for the oversight of the service, from Ministers to senior civil servants to those in charge of regulatory and commissioning bodies, have been bewildered at how this could have happened without it being discovered sooner.

3 Healthcare is not an activity short of systems intended to maintain and improve standards, regulate the conduct of staff, and report and scrutinise performance. Continuous efforts have been made to refine and improve the way these work. Yet none of them, from local groups to the national regulators, from local councillors to the Secretary of State, appreciated the scale of the deficiencies at Stafford and, therefore, over a period of years did anything effective to stop them.

4 As has been frequently pointed out to the Inquiry, the primary responsibility for allowing standards at an acute hospital trust to become unacceptable must lie with its Board, and the

1 In the time period looked at by the Inquiry, Mid Staffordshire General Hospitals NHS Trust was awarded Foundation Trust status and changed its name to the Mid Staffordshire NHS Foundation Trust. Throughout this report the term 'the Trust' has been used to denote both Mid Staffordshire General Hospitals NHS Trust and Mid Staffordshire NHS Foundation Trust.

Trust's professional staff. The system is designed for directors to lead and manage the provision of services within its allocated budget but in accordance with required standards, and for professional staff, informed by their ethical standards and commitment, to serve and protect their patients. If every board succeeded in that challenging task, and if all professional staff complied at all times with the ethics of their professions, there would have been no need for the plethora of organisations with commissioning and performance management responsibilities. It is because of the fact that not all boards are capable of maintaining acceptable standards or improving services at the required pace, or applying effective stewardship to the resources entrusted to them that healthcare systems regulators and performance managers exist. It is because not all professionals do live up to the high standards expected of them that we have professional regulators. All such organisations have the responsibility to detect and redress deficiencies in local management and performance where these occur. It does not need a public inquiry to recognise that this elaborate system failed dramatically in the case of Stafford. As a result, it is clear that not just the Trust's Board but the system as a whole failed in its most essential duty – to protect patients from unacceptable risks of harm and from unacceptable, and in some cases inhumane, treatment that should never be tolerated in any hospital.

5 The enormity of what occurred at this Trust has been consistently acknowledged by both the previous and the present Governments.

6 When presenting the report of the HCC on the Trust to the House of Commons, the Secretary of State for Health, the Rt Hon Alan Johnson MP, said:

> *I apologise on behalf of the government and the NHS for the pain and anguish caused to so many patients and their families by the appalling standards of care at Stafford hospital, and for the failures highlighted in the report.*[2]

7 I was first commissioned in July 2009 by the then Secretary of State for Health, the Rt Hon Andy Burnham MP, to chair a non-statutory inquiry, the principal purpose of which was to give a voice to those who had suffered at Stafford and to consider what had gone wrong there.

8 In announcing the first inquiry, Mr Burnham said:

> *All of us who care passionately about the health service were appalled by the events at Mid Staffordshire, which are in stark contrast to the dedication and professionalism shown by NHS staff every day up and down the country.*

9 It was not within that inquiry's Terms of Reference to examine the involvement of the wider system in what went wrong. What I heard shocked me, and the descriptions of what had

2 Hansard, 18 March, 2009 Column 909

been endured shocked those who read about them in my report, published in February 2010. It was clear to me, as it had been to the victims who gave evidence to me, that there needed to be an investigation of the wider system to consider why these issues had not been detected earlier and to ensure that the necessary lessons were learned.

10 I recommended that such an inquiry be held, a recommendation which was accepted by Mr Burnham, who asked me to chair a further non-statutory inquiry. In announcing that inquiry Mr Burnham told the House of Commons:

> *Let me be clear: the care provided was totally unacceptable and a fundamental breach of the values of the NHS.*[3]

11 He repeated the apology previously given by the Prime Minister:

> *Last year, the Prime Minister apologised to the people of Staffordshire. On behalf of the Government and the NHS, I repeat that apology again today. They were badly let down. I pay tribute to the people who had the courage to come forward and tell their stories and to expose the failures of the past, in order that they could protect others in the future.*[4]

12 Following the general election, Mr Burnham's successor, the Rt Hon Andrew Lansley CBE MP, the first Secretary of State for Health of the Coalition Government, confirmed my appointment but decided that the Inquiry should be a public inquiry under the Inquiries Act 2005. He announced this Inquiry and its Terms of Reference to the House of Commons on 9 June 2010. He told the House:

> *So why another inquiry? We know only too well every harrowing detail of what happened at Mid Staffordshire and the failings of the trust, but we are still little closer to understanding how that was allowed to happen by the wider system. The families of those patients who suffered so dreadfully deserve to know, and so too does every NHS patient in this country.*
>
> *This was a failure of the trust first and foremost, but it was also a national failure of the regulatory and supervisory system, which should have secured the quality and safety of patient care. Why did it have to take a determined group of families to expose those failings and campaign tirelessly for answers? I pay tribute again to the work of Julie Bailey and Cure the NHS, rightly supported by Members in this House.*

3 Hansard, 24 February 2010, Col 309
4 Hansard, 24 February 2010, Col 312

Why did the primary care trust and strategic health authority not see what was happening and intervene earlier? How was the trust able to gain foundation status while clinical standards were so poor? Why did the regulatory bodies not act sooner to investigate a trust whose mortality rates had been significantly higher than the average since 2003 and whose record in dealing with serious complaints was so poor? The public deserve answers.

The previous reports are clear that the following existed: a culture of fear in which staff did not feel able to report concerns; a culture of secrecy in which the trust board shut itself off from what was happening in its hospital and ignored its patients; and a culture of bullying, which prevented people from doing their jobs properly. Yet how these conditions developed has not been satisfactorily addressed.[5]

13 This is the summary of the final report of the Inquiry.

Scope of the Inquiry

Terms of Reference

14 The setting up of the Mid Staffordshire NHS Foundation Trust Public Inquiry was announced to Parliament by the then Secretary of State for Health, the Rt Hon Andrew Lansley CBE MP, on 9 June 2010.

15 The Terms of Reference for this Inquiry are as follows:

- *To examine the operation of the commissioning, supervisory and regulatory organisations and other agencies, including the culture and systems of those organisations in relation to their monitoring role at Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009 and to examine why problems at the Trust were not identified sooner, and appropriate action taken. This includes, but is not limited to, examining, the actions of the Department of Health, the local strategic health authority, the local primary care trusts, the Independent Regulator of NHS Foundation Trusts (Monitor), the Care Quality Commission, the Health and Safety Executive, local scrutiny and public engagement bodies and the local Coroner;*[6]
- *Where appropriate, to build on the evidence given to the first inquiry and its conclusions, without duplicating the investigation already carried out, and to conduct the inquiry in a manner which minimises interference with the Mid Staffordshire NHS Foundation Trust's work in improving its service to patients;*

5 Hansard, 9 June 2010, Column 333
6 This list should also include predecessor bodies of these organisations, where relevant, in accordance with the time period the Inquiry is examining.

- *To identify the lessons to be drawn from that examination as to how in the future the NHS and the bodies which regulate it can ensure that failing and potentially failing hospitals or their services are identified as soon as is practicable;*
- *In identifying the relevant lessons, to have regard to the fact that the commissioning, supervisory and regulatory systems differ significantly from those in place previously and the need to consider the situation both then and now;*
- *To make recommendations to the Secretary of State for Health based on the lessons learned from the events at Mid Staffordshire; and to use best endeavours to issue a report to him by March 2011.*[7]

16 Because this Inquiry has, in accordance with its Terms of Reference, built on the conclusions and evidence of the first inquiry, it is important for this report to be read with the report of the first inquiry.

The first inquiry

17 As stated above, the Terms of Reference for this Inquiry include a requirement to build on the work and conclusions of the first inquiry into the care provided by Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009.

18 That first inquiry was set up by the Rt Hon Andy Burnham MP, the then Secretary of State for Health, when he announced, in a written statement to the House of Commons on 21 July 2009 that he had appointed me to chair an independent inquiry into Mid Staffordshire NHS Foundation Trust.

19 There were a number of events that led to that first inquiry:

- In 2007, concerns were raised about the Trust's mortality rate as compared with other similar trusts. Then in April 2008 the HCC launched an investigation into the Trust, following what it regarded as a concerning reaction by the Trust to the mortality statistics and number of complaints. In March 2009 it published the report of its investigation, which was highly critical of the acute care provided by the Trust.
- During the course of the investigation, and following the publication of the HCC's report, there was an increasing public outcry led by a group of patients and patients' relatives who had experienced poor care at the hands of the Trust. This group, called Cure the NHS (CURE), was led by Julie Bailey, the daughter of Isabella Bailey, an elderly patient who had died in Stafford Hospital. CURE ensured that the issue of the standard of care provided by the Trust remained in the public consciousness, and it campaigned tirelessly for a public inquiry.

7 It was subsequently agreed with the Secretary of State that the extent of the material that had to be examined by the Inquiry made this completion date impractical.

- In a partial response to these publicly expressed concerns, over the course of 2009 the Trust set up an independent case notes review, led by Dr Mike Laker and subsequently managed by the primary care trust. The Secretary of State also commissioned his own reviews: by Dr David Colin-Thomé on the lessons to be learned in relation to commissioning of services; and by Professor Sir George Alberti on the specific issues surrounding emergency admissions at the Trust. Both prepared reports that were published at the end of April 2009.
- None of these reviews or reports satisfied the public concerns as represented by Julie Bailey and CURE, who continued to demand a public inquiry into the failings at the Trust.

20 Ministers did not at that stage agree to set up a public inquiry, but instead commissioned an independent inquiry into the care provided at the Trust. The terms of reference for the first inquiry were as follows:

- *To investigate any individual case relating to the care provided by Mid Staffordshire NHS Foundation Trust between 2005 and 2008* [later amended to March 2009] *that, in its opinion, causes concern and to the extent that it considers appropriate;*
- *In the light of such investigation, to consider whether any additional lessons are to be learned beyond those identified by the inquiries conducted by the HCC, Professor Alberti and Dr Colin-Thomé; and, if so:*
  - *to consider what additional action is necessary for the new hospital management to ensure the Trust is delivering a sustainably good service to its local population;*
  - *to prepare and deliver to the Secretary of State a report of its findings.*

21 As stated by the then Secretary of State, in his Written Ministerial Statement to the House of Commons on 21 July 2009, the focus of the first inquiry was to be on:

> *... ensuring that patients or their families have an opportunity to raise their concerns. It is important, given the events of the past, for those who depend upon the care provided by the trust to be confident that they have been listened to and that any further lessons not already identified by the thorough inquiries that have already occurred be learned.*

22 During the course of the first inquiry, documentary material was obtained from a wide variety of sources, including the Trust, the primary care trust (PCT) and other NHS bodies, the Care Quality Commission (CQC), the SHA, Monitor, CURE, the local authorities and the four local Members of Parliament. The first inquiry was contacted, directly or indirectly, by 966 individual members of the public and some 82 members of staff from the Trust, past and present, and between 2 November and 22 December 2009, the first inquiry heard oral evidence from 113 witnesses.

23 The first inquiry heard harrowing personal stories from patients and patients' families about the appalling care received at the Trust. On many occasions, the accounts received related to basic elements of care and the quality of the patient experience. These included cases where:

- Patients were left in excrement in soiled bed clothes for lengthy periods;
- Assistance was not provided with feeding for patients who could not eat without help;
- Water was left out of reach;
- In spite of persistent requests for help, patients were not assisted in their toileting;
- Wards and toilet facilities were left in a filthy condition;
- Privacy and dignity, even in death, were denied;
- Triage in A&E was undertaken by untrained staff;
- Staff treated patients and those close to them with what appeared to be callous indifference.

24 The first inquiry report was published on 24 February 2010. It contained damning criticism of the care provided by the Trust, drawing out a number of conclusions, including:

- There was a lack of basic care across a number of wards and departments at the Trust;
- The culture at the Trust was not conducive to providing good care for patients or providing a supportive working environment for staff; there was an atmosphere of fear of adverse repercussions; a high priority was placed on the achievement of targets; the consultant body largely dissociated itself from management; there was low morale amongst staff; there was a lack of openness and an acceptance of poor standards;
- Management thinking during the period under review was dominated by financial pressures and achieving FT status, to the detriment of quality of care;
- There was a management failure to remedy the deficiencies in staff and governance that had existed for a long time, including an absence of effective clinical governance;
- There was a lack of urgency in the Board's approach to some problems, such as those in governance;
- Statistics and reports were preferred to patient experience data, with a focus on systems, not outcomes;
- There was a lack of internal and external transparency regarding the problems that existed at the Trust.

25 One of the key issues raised in the report was the role played by external organisations which had oversight of the Trust. The report noted that:

The Inquiry has received a considerable number of representations that there should be an investigation into the role of external organisations in the oversight of the Trust. Concern is expressed that none of them, from the PCT to the Healthcare Commission, or the local oversight and scrutiny committees, detected anything wrong with the Trust's performance until the HCC investigation. While such an investigation is beyond the scope of this Inquiry, local confidence in the Trust and the NHS is unlikely to be restored without some form of independent scrutiny of the actions and inactions of the various organisations to search for an explanation of why the appalling standards of care were not picked up. It is accepted that a public inquiry would be a way of conducting that investigation, but also accepted that there may be other credible ways of doing so.[8]

26 One of the key recommendations arising from the first inquiry report was:

> *52. Having considered the evidence and representations referred to in Section H, I conclude that there is a need for an independent examination of the operation of each commissioning, supervising and regulatory body, with respect to their monitoring function and capacity to identify hospitals failing to provide safe care: in particular:*
>
> - *what the commissioners, supervisory and regulatory bodies did or did not do at Stafford;*
> - *the methods of monitoring used, including the efficacy of the benchmarks used, the auditing of the information relied on, and whether there is a requirement for a greater emphasis on actual inspection rather than self-reporting;*
> - *whether recent changes, including the 'Memorandum of Understanding' between Monitor and the Care Quality Commission (CQC), Quality Accounts and the registration of trusts by CQC, will improve the process by which failing hospitals are identified;*
> - *what improvements are required to local scrutiny and public engagement arrangements; and*
> - *the resourcing and support of foundation trust governors.*
>
> *53. This Inquiry has received many demands that there should be a public inquiry. One of the elements of such an inquiry, it has been suggested, should be the investigation of the external bodies mentioned above. I do not consider it is appropriate for me to suggest that a public inquiry (in the sense of an Inquiries Act inquiry) is the only way in which these issues can be addressed, but it is certainly a way in which it could be done.*

8 Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005–March 2009, Volume 1, HC375-1 (24 Feb 2010), page 23, paragraph 75

Recommendation 16: The Department of Health should consider instigating an independent examination of the operation of commissioning, supervisory and regulatory bodies in relation to their monitoring role at Stafford hospital with the objective of learning lessons about how failing hospitals are identified.[9]

27 The DH and the Trust Board accepted the recommendations of the first inquiry in full.

28 In response, and to support all NHS organisations to learn from and respond to the recommendations of the report, the DH published three reports designed to help embed effective governance and detect and prevent such serious failures occurring again:

- *Review of Early Warning Systems in the NHS*, which described the systems and processes, and values and behaviours which make up a system for the early detection and prevention of serious failures in the NHS;[10]
- *Assuring the Quality of Senior NHS Managers*, which set out recommendations to further raise the standards of senior NHS managers;[11]
- *The Healthy NHS Board,* which set out guiding principles to allow NHS board members to understand the collective role of the board and individual role of board members, governance within the wider NHS and approaches that are most likely to improve board effectiveness.[12]

29 The Secretary of State accepted a recommendation to consider asking Monitor to de-authorise the Trust when the power came into effect.

30 The Secretary of State also accepted Recommendation 16 of the first inquiry report and proposed that I chair an inquiry on a non-statutory basis, with the presumption that it would sit in public.

What went wrong and where

31 As seen above, the Terms of Reference[13] require this Inquiry to examine the involvement of numerous agencies with the events at the Mid Staffordshire NHS Foundation Trust within a defined period: January 2005 to March 2009. In doing so, this report builds on the findings of the first inquiry and the previous report of the HCC, and only reconsiders what is said where new evidence has thrown more light on what occurred. While observations will be made about the conduct of the business of the Trust and on some of those responsible, this report does not amount to a complete rehearsal or review of what has been found not only by the

9 Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005–March 2009, Volume 1, HC375-1 (24 Feb 2010), page 415, paragraph 52
10 DH00000000628 *Review of Early Warning Systems in the NHS: Acute and community services*, (February 2010), National Quality Board
11 Assuring the Quality of Senior NHS Managers – Final Report (24 Feb 2010), PricewaterhouseCoopers LLP
12 EMB/1 WS0000022551
13 See Annex A

first inquiry but also the HCC investigation and other reports. To have conducted such a review would have led to an unnecessary and disproportionate extension to an already complicated and lengthy process.

32 The Inquiry has been helped considerably by evidence from the Trust's patients, and those close to them, and has heard many harrowing stories. The principal focus of this Inquiry in receiving their evidence has been to understand their experiences of the wider system of the NHS in pursuing their complaints and concerns. Another principal purpose of this Inquiry has been to look at the interactions between the Trust and the various agencies which had responsibility for oversight, commissioning and regulation of healthcare services and professionals at the relevant time. For this reason it was not considered necessary to obtain or have regard to evidence from as wide a range of witnesses from within the Trust as might have been the case if this had been an inquiry focused on a formal investigation of its internal workings.

33 The interaction of the Trust with various other organisations has also been looked at. These are bodies which, while having no statutory, managerial or regulatory responsibilities in relation to the Trust's activities, had access to information which might have been helpful in detecting what was going wrong there or may have a contribution to make with regard to improvements in culture, training and support of healthcare professionals and managers working there.

34 It must be emphasised that it has not been within the Inquiry's remit to examine alleged failures of the system with regard to other trusts and services. Unhappily, the Inquiry received more than one request that it should do so, and all have had to be declined. Arguments were on occasion advanced that examination of events at other places would throw light on what went wrong in Stafford or in other parts of the healthcare system. To have explored such arguments by evidence would have been speculative and would have led to lines of enquiry in respect of which, once they were embarked upon, it would be difficult to know when it was appropriate to stop. In other words, this would have become not just a long inquiry but an endless one. The inability of the Inquiry to look into such matters, however, should not be taken to mean that I have made any determination that the matters of this nature raised were of no substance. I have simply decided that they were not to be regarded as within my Terms of Reference. In passing, I should observe that many of those who wrote to me with requests to look at issues arising elsewhere were clearly deserving of great sympathy, and their need to approach me in some cases bore witness to their inability to obtain satisfaction from the complaints and redress systems available to them.

35 I deal with the issue of whether any inferences may properly be drawn as to the existence of similar problems elsewhere in the service later in this Introduction (see 'Extrapolation' below).

Geographical and institutional limitations

36 The disaster of Stafford Hospital occurred in an NHS acute hospital provider trust, and it is the lessons to be learned from that which I have been asked to identify. Of necessity, this Inquiry has focused on the NHS in England and the arrangements for directly provided NHS care. NHS hospital care is also provided by independent providers through NHS funding arrangements. NHS providers share a regulator with providers of independently funded care. Different arrangements apply in Wales, Scotland and Northern Ireland for NHS care. Primary care is subject to a different regime. This report will not specifically address how the lessons from Stafford might be applied to those different parts of the health economy, but there are likely to be implications in the lessons and recommendations for other sectors which must be borne in mind in implementing them by those charged with doing so.

Lessons

37 The other main duty imposed on the Inquiry by its Terms of Reference has been to identify the lessons to be learned from the Stafford experience for the future, having regard to the system as it is now constituted. This has required the Inquiry to inform itself about the changes that have taken place since 2009. Given the pace of reform and procedural change during the lifetime of the Inquiry, this has been no easy task. The Inquiry sought to inform itself of those which have taken place since the close of the oral hearings and which are in the public domain. Wherever it has been deemed relevant, reference has been made to them in the text. This report should not, however, be understood as intending to offer a comprehensive and up to the minute account of the current position.

38 A number of organisations in existence during the period 2005 to 2009 have been abolished since, and others have been created. It has not been within the remit of the Inquiry to investigate the workings of these new bodies except to the extent thought necessary to inform the Inquiry about how the system now operates. That consideration has not extended to examine whether specific interventions in respect of other trusts or even the Trust have been deficient or effective, although the Inquiry has been invited to do so. This would not have been within its remit. However, in some instances the culture within the new system has been looked at and observations will be made about it.

39 Clearly some of the changes that have taken place have been the subject of considerable controversy, in particular the reforms to commissioning now enacted in the Health and Social Care Act 2012. It has not been within the remit of the Inquiry to examine the merits of the arguments for or against these reforms. There are many differing opinions on the best way to provide healthcare to the public in accordance with the founding principles of the NHS, but the focus of this Inquiry has been relentlessly on the need to protect patients from unacceptable and unsafe care. That should be possible to achieve whatever the system of provision. In general, it is unlikely to be structural changes in the system which enhance safety, although there may be many other reasons for making them. Within any system there is a need to

ensure a relentless focus on ensuring patient safety and the provision of at least a minimum quality of care. That should not be too much to ask of any system.

Recommendations

40 There are 290 recommendations in the report. They occur at various places throughout the report but have been grouped according to themes identified by the Inquiry, and are presented in a table in *Chapter 2* of this summary and in *Chapter 27* of the report. They are also highlighted in the report at the end of relevant chapters. Where possible, recommendations identify the organisation it is suggested should take them forward. Where, for whatever reason, this has not been thought possible it would be for the DH to ensure that they are taken forward. Some recommendations are of necessity high level and will require considerable further detailed work to enable them to be implemented. They seek to take account of the system as now structured. In correspondence with the Inquiry the DH confirmed that the recent reforms would not pre-empt consideration of them.

41 The experience of many previous inquiries is that, following the initial courtesy of a welcome and an indication that its recommendations will be accepted or viewed favourably, progress in implementation becomes slow or non-existent. It is respectfully suggested that the subject matter of this Inquiry is too important for it be allowed to suffer a similar fate. The suffering of the patients and those close to them described in the first inquiry report requires a fully effective response and not merely expressions of regret, apology and promises of remedial action. They have already been at the receiving end of too many unfulfilled assurances for that to be acceptable. What is required is a means by which it is clear not only which of the recommendations has been accepted, by whom, and what progress is being made with implementation, but above all how the spirit behind the recommendations is being applied. All organisations that are or should be involved in implementation should account for their decisions and actions in this regard. While the implementation process could benefit from coordination by the DH, many recommendations can be directly implemented by other bodies. While the theme of the recommendations will be a need for a greater cohesion and unity of culture throughout the healthcare system, this will not be brought about by yet further "top down" pronouncements but by engagement of every single person serving patients in contributing to a safer, committed and compassionate and caring service. Therefore, the first recommendation of the report relates to the potential oversight of and accountability for implementation of its recommendations:

42 It is recommended that:

- All commissioning, service provision, regulatory and ancillary organisations in healthcare should consider the findings and recommendations of this report and decide how to apply them to their own work;

- Each such organisation should announce at the earliest practicable time its decision on the extent to which it accepts the recommendations and what it intends to do to implement those accepted, and thereafter, on a regular basis but not less than once a year, publish in a report information regarding its progress in relation to its planned actions;
- In addition to taking such steps for itself, the Department of Health should collate information about the decisions and actions generally and publish on a regular basis but not less than once a year the progress reported by other organisations;
- The House of Commons Select Committee on Health should be invited to consider incorporating into its reviews of the performance of organisations accountable to Parliament a review of the decisions and actions they have taken with regard to the recommendations in this report.

Constitution of the Inquiry

Panel

43 No panel was appointed to sit with me. Accordingly the daunting task of fulfilling the Terms of Reference has been my responsibility and mine alone. Therefore, the narrative, analysis findings and recommendations are also mine and mine alone, arrived at having regard to all the evidence placed before the Inquiry.

Assessors

44 To assist me in that task I appointed a number of assessors, which I was entitled to do under Section 11 of the Inquiries Act 2005.[14] Their function has been to offer me advice on matters within their expertise. Three of the assessors assisted me during the first inquiry and therefore brought with them a direct experience of the issues exposed by it. One gave expert evidence at this Inquiry and, as did three other assessors, contributed to the seminars which formed part of the material gathered.

45 The assessors were appointed in two stages. The first group were involved from the outset of the Inquiry and were in a position to offer me explanations, context and advice on the evidence as it emerged allowing me a greater understanding of what I was being told. I have also benefited from their immense experience in various aspects of the healthcare and other systems in identifying the issues arising for the system. I did not invite them to attend the oral hearings, but they were provided with access to the transcripts. I did not think it necessary for the performance of their function to attend oral hearings, and it would in practice have been very difficult to find assessors of the authority and experience of this panel who would have been able to make the time available to attend the many weeks of hearings.

14 A list of assessors and a summary of their qualifications and backgrounds appears at Annex D in the main report.

46 The second group were appointed after the close of the oral hearings with the specific remit of advising me in relation to the likely effectiveness of recommendations I was proposing to make. Their task was not to propose any recommendations but to allow me to reflect with them on the extent to which the recommendations I wished to make would help to address the problems this sad story has revealed.

47 I have not thought it necessary or desirable to have prepared or to publish a note of my discussions with the assessors, and no written reports have been sought or provided. Their function has been to act as a sounding board and to challenge and advise me. It is not proposed to disclose the content of any advice, whether written or oral.

48 I must place on record my deep gratitude to the assessors for the patience and dedication with which they have gone about their tasks. I could not have completed the report without their assistance.

The legal team

49 Counsel to the Inquiry, Tom Kark QC, and his juniors, Ben Fitzgerald, Tom Baker and Joanna Hughes have performed with great distinction the onerous task of analysing the vast quantity of evidential material made available to the Inquiry and presenting evidence and submissions at the oral hearings. They have continued to assist me as legal advisers and have been of immense assistance in all the procedures that have been undertaken.

50 Both Counsel and I have been privileged to receive the constant help of the Solicitor to the Inquiry, Peter Watkin Jones, his principal assistants Sarah Garner, Luisa Gibbons, Catherine Henney and Isabelle Makeham and the rest of his team from Eversheds.[15] To them fell the task of the initial sorting and analysis of well over a million pages of raw material disclosed to the Inquiry by the core participants and others, approaching and interviewing witnesses, preparing witness statements and the general legal conduct of the Inquiry. They too are owed a huge debt of gratitude for making order out of potential chaos and allowing the Inquiry to be conducted in as orderly a fashion as possible.

51 This Inquiry, like most modern public inquiries, has been run on a strictly non-adversarial basis with the result that representatives of core participants were generally expected to propose lines of questioning they wanted to be pursued with the legal team. The core participants were entitled to raise with me any concerns and to apply to ask questions directly if not satisfied with the conduct of questioning by Counsel to the Inquiry. It is a significant tribute to the legal team that core participants felt it necessary to make such an application on extremely rare occasions.

15 A full list of the Solicitor's team, along with the rest of the Inquiry team, appears at Annex B in the main report.

The Secretariat

52 The Secretary to the Inquiry, Alan Robson, his deputy Catherine Pearson and his team have met the challenge of the setting up of the infrastructure, providing the face of the Inquiry to the public and coping with the myriad of tasks required to maintain and bring the process to a conclusion.[16] It may come as a surprise for some to appreciate that there is no effective established template for the setting up or administration of a public inquiry and, therefore, the team has had to start from scratch. I am sure I am not the first chair of an inquiry to wonder why it is necessary for the wheel to be reinvented in relation to the many administrative and logistical details without which an inquiry cannot function. However, Mr Robson and his team rose magnificently to this challenge. They deserve particular praise for their caring and sensitive support given to witnesses to the Inquiry, many of whom faced great difficulties in taking this step.

The core participants and their representatives

53 Thirteen organisations applied or were invited to be core participants. This status gave them access to evidential material in advance of it being adduced in evidence, and they were, as indicated above, able to suggest lines of inquiry to the legal team. They were entitled to be legally represented and to make submissions to the Inquiry. Without exception, they used these rights proportionately and constructively in a manner which was of great assistance.

Liaison between the Inquiry and the core participants and the public

54 The Inquiry, through the Solicitor and the Secretary's teams, sought to keep the core participants, and the wider public, informed of the conduct of its business as it has proceeded. This has largely been done through the Inquiry website, though there has been regular correspondence and meetings with core participants on procedural matters and with the wider public and press who have been in touch with the Inquiry Secretary's team in writing, in person and on the telephone. For the duration of the hearings, the whole Inquiry team was located and worked from the hearing venue at Stafford Borough Council Offices.

55 The website has also sought to inform relevant parties of the Inquiry's intentions and procedures as they have unfolded, rather than after the event. Procedural protocols and statements have been issued (after consultation as necessary) and posted to the Inquiry's website on issues such as procedures to be adopted, a media protocol, a protocol for seeking legal representation at public expense, a protocol on the issue of warning letters under Rule 13 of the Inquiry Rules 2006, together with other key documents, such as the issue of restriction notices, the circumstances of accepting new evidence after close of evidence, and the details of the Inquiry's costs.

16 A full list of the Secretariat appears at Annex B in the main report.

56 Evidence and submissions have also been made available online. All core participants were provided with advance notice through the Inquiry's database of the statements and exhibits of witnesses who were to give evidence and indeed of those with possibly relevant evidence to give, but where the Inquiry had decided not to call the witness in person. Schedules of the timetabling of witnesses to give oral evidence were made publicly available in advance of witnesses being called. The statements of witnesses and their exhibits have generally been made available to the public and press via the website on the day the witnesses gave oral evidence. A livenote transcript was taken of all evidence given and that was generally posted on the evening of the giving of evidence too. Submissions made by the legal representatives of the core participants and of Counsel to the Inquiry were also made available on the website.

Seminars

57 Following the end of the public hearings, I organised a series of seven seminars where invited speakers, attendees, members of the public and press had an opportunity to come and discuss various topics that I had set out on the Inquiry website. I commissioned papers and/or presentations from the invited speakers, and these are all available on the Inquiry website.

58 The seminars covered:

- Methods of regulation, which was held on 13 October 2011 in Manchester;
- The training and development of trust leaders, which was held on 18 October 2011 in Leeds;
- Information, which was held on 19 October 2011 in Leeds;
- Organisational culture, which was held on 25 October 2011 in London;
- Nursing, which was held on 31 October 2011 in London;
- Patient experience, which was held on 2 November 2011 in Stafford;
- Commissioning, which was held on 3 November 2011 in London.

59 All seven seminars were facilitated by Dr Sarah Harvey, who also produced a report of the seminars that was published in hard copy and is available on the Inquiry website.

60 I also undertook a small number of visits to healthcare organisations, and a list of those visited is set out at Annex E in the main report.

Witnesses

61 Some 164 witnesses gave oral evidence. In addition, a further 87 witness statements and 39 provisional statements were 'read' into the Inquiry's record and were accepted into evidence. The Inquiry took 352 individual witness statements in total but some of these were not deemed material or relevant to the Inquiry's business. Those who assisted the Inquiry by

re-living their experiences of poor care and poor handling of their complaints did so with great dignity, patience and care. I am indebted to them for their invaluable assistance and acknowledge the cost in suffering that must have been incurred by many of them in doing so.

62 The Inquiry also heard from a vast range of healthcare professionals, officials, politicians and others involved in the complexities of commissioning, performance management, oversight and regulation of the healthcare system. The experience will have been stressful for nearly all of them, but the Inquiry is grateful to all for their assistance. It would have been surprising if I had been able to agree with the recollections or views of every witness, but I am satisfied that without exception they were all doing their honest best to tell me the truth as they saw it.

63 Not all witnesses were asked to give oral evidence. In the main this was because what they had to say was sufficiently contained in a written statement and little additional benefit would have been obtained from oral examination. In one significant case, that of Mr Martin Yeates, the former Chief Executive of the Trust, he was excused from giving oral evidence for medical reasons, which I was satisfied, following receipt of a report of an independent medical examination commissioned by the Inquiry, rendered him unfit to attend to give oral evidence. He was, however, able to provide a substantial written statement to the Inquiry following an interview by the Solicitor to the Inquiry.

64 Two witnesses were excused, because of medical reasons, the normal requirement of giving their oral evidence in the Inquiry chamber in the presence of the public, but they were allowed to do so in a separate room and one from a separate location, with what they said being relayed live to the public.

65 The Inquiry also had the benefit of a range of expert evidence from witnesses appointed by the Inquiry as experts for this purpose. I would like to express my gratitude for their deep understanding of the system and its history that this evidence brought to the process.

Hindsight

66 Professor Sir Brian Jarman pointed out in his evidence to this Inquiry that at the Bristol Inquiry, in which he was a member of the inquiry panel, there were 120 mentions of the word "hindsight" in the evidence. The Bristol Inquiry report contained a section on hindsight. In the Foreword, the panel expressed the hope that the disaster that had been uncovered there would not be repeated:

It would be reassuring to believe that it could not happen again. We cannot give that reassurance. Unless lessons are learned, it certainly could happen again, if not in the area of paediatric cardiac surgery, then in some other area.[17]

67 Professor Jarman told this Inquiry that although he had doubts whether the DH would actually implement the recommendations of the Bristol Inquiry:

I did feel at least there would be no excuse in future for those responsible to continue to say, after the Bristol report was published, as they had said to us throughout the Bristol Inquiry, "with the benefit of hindsight".[18]

68 Unhappily, the word "hindsight" occurs at least 123 times in the transcript of the oral hearings of this Inquiry, and "benefit of hindsight" 378 times.

69 It is of course inappropriate to criticise individuals or organisations for failing to apply fully the lessons to be learned from the knowledge that is now available, and accepting in the light of that knowledge, not possessed at the relevant time, that more or earlier intervention should have occurred. It must be accepted that it is easier to recognise what should have been done at the time now that the enormity of what was occurring in the Trust is better known.

70 There is, however, a difference between a judgement which is hindered by understandable ignorance of particular information and a judgement clouded or hindered by a failure to accord an appropriate weight to facts which were known.

71 It has been said before and must be said again; I do not for a moment believe that those in responsible positions in the Trust or elsewhere in the healthcare system went about their work knowing that by action or inaction they were contributing to or condoning the continuance of unsafe or poor care of patients. What is likely to be less comfortable for many of those in such posts at the time is the possibility, and sometimes the likelihood, that whatever they believed at the time, they were not being sufficiently sensitive to signs of which they were aware with regard to their implications for patient safety and the delivery of fundamental standards of care.

Extrapolation

72 Some of the responses to Rule 13 letters, ie letters warning of potential criticisms, have asserted that it is impermissible to extrapolate from the events at Stafford a conclusion that such deficiencies are to be found elsewhere. This Inquiry has not, of course, investigated the state of affairs at any other trust. I have received several requests to do so from distressed

17 Jarman WS0000042749, para 38
18 Jarman WS0000042749, para 38

members of the public, but to have done so would not have been within my Terms of Reference. Therefore, I have been offered arguments that it would be unsafe in the absence of evidence to assume that significant changes are necessary to detect or prevent another such catastrophe.

73 The first point to make is that even if it were true that there were no other provider within the healthcare system which displayed the combination of deficiencies found at the Trust, it is of very grave concern that the extensive system of checks and balances intended to detect and prevent such failures did not work. Large numbers of patients were left unprotected, exposed to risk, and subjected to quite unacceptable risks of harm and indignity over a period of years. Whatever else can be said, the deficiencies at Stafford were wide in scale and adversely affected considerable numbers of patients and those close to them.

74 The second point is that it has not escaped the Inquiry's notice that even since the HCC report on the Trust there have been a series of highly concerning reports of experiences elsewhere containing echoes of what was experienced within the Trust. In the Patient Association's (PA's) closing submission to the Inquiry, they make reference to a number of highly critical reports, including: their 2009 report *Patients Not Numbers, People Not Statistics*; the 2009 report published by National Confidential Enquiry for Patient Deaths (NCEPOD), which reviewed the care of patients who died within four days of admission; the Alzheimer's Society report *Counting the Cost;* and their own report from 2010, *Listening to Patients, Speaking up for Change*.[19] There have been others, too, such as the Care Quality Commission (CQC) report in 2011 on dignity and nutrition for older people[20] and the well documented events of appalling care provided at Winterbourne View to name but two. Even if all the instances contained in the reports just mentioned are in some way isolated ones dependant on particular circumstances, they are suggestive that there are places where unhealthy cultures, poor leadership, and an acceptance of poor standards are too prevalent.

75 The third point is that the failure of the system to detect the deficiencies at the Trust and take effective action soon enough means that the public is unlikely to have confidence that "another Stafford" does not exist, in the absence of being convincingly persuaded that sufficient change has taken place.

76 Therefore, Stafford was not an event of such rarity or improbability that it would be safe to assume that it has not been and will not be repeated or that the risk of a recurrence was so low that major preventative measures would be disproportionate. The consequences for patients are such that it would be quite wrong to use a belief that it was unique or very rare to justify inaction.

19 CLO000001209, *Patient's Association closing submissions*, pages 2–3
20 *Dignity and Nutrition Inspection Programme,* (October 2011), Care Quality Commission, www.cqc.org.uk/sites/default/files/media/documents/20111007_dignity_and_nutrition_inspection_report_final_update.pdf

Similarity to others

77 An opposite argument was used, sometimes by those also espousing the extrapolation argument in other contexts, to justify inaction or a lack of a response. This was that matters of potential concern at Stafford, such as outlying mortality rates, concerns about governance, and staffing issues, could be found at many other places, and therefore were justifiably regarded as not being of particular significance or of requiring exceptional action.

78 In some instances, such an argument betrays a failure to appreciate the impact on patients and those close to them, of the deficiency in question. It is the institutional equivalent of the tolerance of poor care all too frequently seen and not challenged on some wards at the Trust. The fact that it might be typical of what happened elsewhere is cause for increased concern not reassurance. It is an argument which evidences a culture of habituation and passivity in the face of issues which may indicate real suffering. It is an attitude which would be unlikely to be persisted in if those adopting it were constantly to place an empathy for the predicament of patients at the forefront of their mind.

Standard of proof

79 In arriving at conclusions with regard to the relevant facts, the panel of a public inquiry finds itself in a different position to a court of law, whether civil or criminal. A court of law is required to make specific findings in relation to allegations made or charges before it in accordance with the relevant law. Issues are decided after the presentation of evidence and argument by each opposing party. In a criminal court charges may not generally be found proved unless the court is satisfied on the evidence so that it is sure of that matter. In civil proceedings the rule is generally that a fact will only be found proved if the court is satisfied of it on the balance of probabilities. In civil proceedings the more serious the allegation the more cogent will be the evidence required to prove it.

80 By contrast, at a public inquiry such as this one the process is inquisitorial, in that it takes the form of an investigation led by the inquiry and not by any of the parties. There are Terms of Reference but no more closely defined allegations or issues which have to be determined. There are no parties entitled as of right to call evidence of their own. The task of the inquiry is not to determine an allegation or a charge, and its findings are not determinative of civil or criminal liability. It is required to examine events that have occurred and identify lessons which in its opinion can be drawn from those events. It may as a matter of judgement identify criticisms it considers can be made of individuals or organisations arising from those events, but such findings are not binding on those criticised.

81 The Inquiries Act 2005 and the Inquiry Rules 2006 offer no specific guidance on the subject of the standard of proof to follow, beyond Section 17 of the Act which provides that subject to any provision of the Act or the rules:

... the procedures and conduct of the Inquiry are to be such as the chairman of the inquiry may direct.

82 The overriding requirement of the Act, set out in section 17(3), is that in any decision made by the chairman as to procedure or conduct of the Inquiry:

... the chairman must act with fairness and with regard also to the need to avoid any unnecessary cost ...

83 There is much legal authority on what is the appropriate standard of proof in civil and criminal proceedings, but this is of little relevance to an inquiry because of the differences in character between the public inquiry process and such proceedings mentioned above.

84 Some assistance can be gained from the rulings made by chairs of previous public inquiries on the issue.

85 In the Shipman Inquiry, Dame Janet Smith set out the approach of that inquiry to the standard of proof in her first report, in effect declining to be constrained by any one standard of proof:

9.43 In an inquiry such as this, there is no required standard of proof and no onus of proof. My objective in reaching decisions in the individual cases has been to provide an answer for the people who fear or suspect that Shipman might have killed their friend or relative. I have also sought to lay the foundation for Phase Two of the Inquiry. My decisions do not carry any sanctions. Shipman has been convicted of 15 cases of murder and sentenced appropriately. He will not be tried or punished in respect of any other deaths. Nor will my decisions result in the payment of compensation by Shipman. It is possible that relatives might recover damages from Shipman if they can show that Shipman has killed their loved one, but my decision that he has done so will not automatically result in an award of compensation against him. Accordingly, I have not felt constrained to reach my decisions in the individual cases by reference to any one standard of proof.[21]

86 At the Bloody Sunday Inquiry, Lord Saville of Newdigate rejected the application of the criminal standard of proof:[22]

8. In the context of the present Inquiry, there is no question of the Tribunal having any power to remove or diminish the rights, liberties or freedoms of anyone. It is not the function of an Inquiry of the present kind to determine rights and obligations of any nature. Its task, set by Parliament, is to inquire into and report upon the events on Sunday

21 *Shipman Inquiry First Report* (19 July 2002) chapter 9, www.shipman-inquiry.org.uk/fr_page.asp?ID=133
22 The Bloody Sunday Inquiry: Standard of Proof Ruling (11 October 2004)

30 January 1972 which led to loss of life in connection with the procession in Londonderry on that day, taking account of any new information relevant to events on that day. The Inquiry cannot be categorized as a trial of any description. Unlike the courts it cannot decide the guilt (or innocence) of any individual or make any order in its report. Our task is to investigate the events of Bloody Sunday, to do our best to discover what happened on that day and to report the results of our investigations. It accordingly follows that the considerations that led the courts in the cases cited to require proof to a very high standard before making orders that affected the rights, liberties and freedoms of individuals are no guide to the task entrusted to the Tribunal.

87 After referring to Dame Janet Smith's approach quoted above, Lord Saville went on:

10. We consider that these observations are apt in our consideration of the events of Bloody Sunday ...

17. In our view therefore the cases cited to us do not provide any support for the proposition that as a matter of principle we cannot make any findings implying criminality unless we are satisfied to the criminal standard of proof or of serious misconduct unless we are satisfied to the enhanced civil standard.

18. As we have said earlier, since we are an Inquiry and not a Court (criminal or civil) we cannot give a verdict or pass a judgement on the question whether an individual was guilty of a specific crime or legally recognised serious wrongdoing. For the same reason the terminology and requirements of the criminal or civil law are largely inapplicable. Thus it seems to us that we can and should reach conclusions without being bound by rules designed for court cases, such as who has the burden of proof and the strict rules of evidence ...

88 Referring to a judgment in a Canadian case[23] he said:

19. ... As he pointed out, the findings of a commission of inquiry relating to an investigation are simply findings of fact and statements of opinion reached by the commission at the end of the day; and though they may affect public opinion, they are not and cannot be findings of criminal or civil responsibility.

89 Lord Saville considered and rejected a submission that not to apply a high standard of proof would be unfair to the individuals concerned:

22. The Inquiry is indeed concerned with matters of the greatest seriousness. The question whether the shooting of civilians by soldiers was or was not justified is central. The very subject matter of the Inquiry raises the possibility that individuals may be the subject of

23 *Canada (Attorney-General) v Canada (Commission of Inquiry on the Blood System)* 1997 3 S.C.R. 440

the most serious criticism and there may well be wide publicity, though it should be noted that most of those concerned have been granted anonymity. But for the Tribunal to conclude that while it was not sure, nevertheless it seemed probable that a particular shooting was deliberate and unjustified (objectively and subjectively) could hardly create or increase a risk of prosecution; indeed it would be more likely to have the opposite effect. Furthermore, apart from the reference to the possible risk of prosecution, no attempt was made to explain what 'serious consequences' would follow were the Tribunal not to apply the suggested standards of proof, save that it was also suggested that the media would be likely to misrepresent the views of the Tribunal, and categorize the individual as being guilty without reference to the degree of confidence or certainty expressed by the Tribunal in making any findings implying criminality or serious misconduct. The fact (if such it be) that the media may misrepresent the views of the Tribunal does not seem to us to be a sound or satisfactory basis for requiring the Tribunal to refrain from expressing those views.

23. In our view, provided the Tribunal makes clear the degree of confidence or certainty with which it reaches any conclusion as to facts and matters that may imply or suggest criminality or serious misconduct of any individual, provided that there is evidence and reasoning that logically supports the conclusion to the degree of confidence or certainty expressed, and provided of course that those concerned have been given a proper opportunity to deal with allegations made against them, we see in the context of this Inquiry no unfairness to anyone nor any good reason to limit our findings in the manner suggested ...

24. It was also submitted that there would be no point in reaching conclusions on matters implying criminality or serious misconduct, unless we were sure beyond a reasonable doubt. We do not understand this submission. We are asked to investigate and report on an event that took place some three decades ago, where on any view soldiers of the British Army shot and killed (and wounded) a number of civilians on the streets of a city in the United Kingdom and where the question whether or not they were justified in doing so has been the subject of such debate ever since that it led to the institution of this (the second) Inquiry some thirty years later. It seems to us that it would be quite wrong to confine ourselves in relation to this central part of the Inquiry to making findings where we were certain what happened. On the contrary, it is in our view our duty to set out fully in our Report our reasoned conclusions on the evidence we have obtained and the degree of confidence or certainty with which we have reached those conclusions. We are not asked to report only on these central matters on which the evidence makes us certain.

27 ... we are not persuaded by the arguments that seek to impose on us the criminal or enhanced civil standard of proof in relation to findings implying criminality or serious misconduct falling short of criminality. We should emphasise, as we have made clear on numerous occasions during the course of the Inquiry, that this does not mean that we shall entertain or allow to be pursued allegations of this kind which have no sensible

foundation at all or in respect of which the individual concerned has not been given a proper opportunity to answer.

90 The effect of this ruling was that the inquiry could make findings of fact while describing the degree of confidence with which those were made. This was not thought to be unfair, provided there was a foundation of evidence and a logical basis for the finding and the individual to whom the finding was adverse was given a fair opportunity to answer the allegation.

91 It is right to note that both the Shipman and the Bloody Sunday inquiries were set up under the now repealed Tribunals of Inquiry (Evidence) Act 1921, but nothing appears to turn on this.

92 The Baha Mousa Public Inquiry was set up under the Inquiries Act 2005. Sir William Gage, after hearing submissions, gave a ruling on the standard of proof to be applied. He ruled that he would apply the civil standard of proof. His reasoning appears in the following passages:[24]

18 All counsel stressed that in making my findings I am required to act fairly. Of course, I am well aware of the need to be fair to soldiers and others whose reputations and careers may be affected by my findings. Throughout the Inquiry I have endeavoured with Counsel to the Inquiry to ensure that those who may be open to criticisms are treated fairly and I am grateful to Mr Singh for his endorsement that the level of natural justice afforded to those who may be criticised has been 'above and beyond' the strict requirements of the 2006 Rules.

19 I must also be fair to the detainees who, on any view of the evidence I have so far heard, suffered serious and traumatic injuries following their arrest and detention in the TDF at Battlegroup Main between 14 and 16 September 2003. In addition, this is a Public Inquiry and it is in the public interest that my findings in the Report are expressed in such a way as can be readily understood as my judgement on what occurred, who was responsible and why I have made recommendations. In my opinion, this can best be achieved by adopting the flexible and variable standard of proof as applied in the Shipman Inquiry.

20 I recognise that in relation to some issues in this Inquiry, the more serious the allegation the more cogent must be the evidence to support a finding of wrongdoing. I must as a matter of fairness bear in mind the consequences of an adverse finding to any individual against whom serious allegations are made. However, by section 2 of the 2005 Act, I have no power to determine criminal liability, and the mere fact that criminal culpability might be inferred from my findings, does not in my judgement mean that I must adopt the criminal standard in making findings of fact. On the contrary, I think that

24 *The Report of the Baha Mousa Inquiry: Volume 1*, HC 1452-I (8 September 2011), chapter 6

the usual starting point will be to apply the civil standard but taking account of the 'inherent improbability' concept where it properly applies.

21 There are some cases where criminal conduct is considered in the criminal courts applying the criminal standard of proof, the facts of which arise in later civil litigation where the balance of probabilities standard falls to be applied. In order properly to report who is responsible, in my judgement, I must reserve to myself the right to state, where I find the evidence sufficient, that I find a fact proved on a balance of probabilities. To do otherwise would necessarily be to limit my findings of responsibility to the high criminal standard.

22 This does not mean, however, that I shall disregard the criminal standard of proof. There may be factual issues involving allegations of serious misconduct against identifiable individuals, where I shall wish to make clear that although I am satisfied on the balance of probabilities that an individual was involved in misconduct, the evidence is not sufficient to establish that fact to the criminal standard. There may equally be factual issues where I am satisfied to the criminal standard either that an individual was involved in particular misconduct or that he can be exonerated of such misconduct. In such cases, I may again think it right to make clear in my report that I am able to reach those findings to the criminal standard. The important point is that where issues of misconduct are concerned, I must make clear the standard of proof (be it civil or criminal) to which I have been satisfied in making the relevant finding.

23 So far as all other allegations or factual disputes are concerned, in applying the balance of probabilities standard of proof the concepts of 'inherent improbabilities' and 'the commonsense approach' [sic] *when reaching findings are concepts with which all judges of fact at first instance are familiar. These are factors which I shall have well in mind when reaching findings of fact on a balance of probabilities.*

24 During the course of oral argument I canvassed with all counsel whether or not I am entitled to make comments expressing suspicion or, some other such phrase, that an allegation is true. Mr Singh submitted that I am entitled to do so; others disagreed. Mr Beer submitted that I have no power to do so because my power is only to determine the facts (s.24(1)(a) of the 2005 Act).

25 I do not accept that I may not make such comments. In my opinion the terms of s.24(1)(a) do not restrict me from doing so. In any event, as Mr Singh pointed out, s.24(1) of the 2005 Act provides that 'The report may also contain anything else that the panel considers relevant to the Terms of Reference'. I do, however, accept and stress that by making a comment of that nature I would not be making a finding of fact. I further accept that the power to make such a comment should be exercised sparingly. Circumstances in which I will feel constrained to do so will, I believe, be comparatively rare.

93 It is to be noted that although Sir William decided that in principle he would be applying the civil standard of proof, he considered he had power to make comments not amounting to findings of fact in the nature of expressions of suspicion.

94 Sir William appears to have understood the approach of the Shipman Inquiry to have been to apply the "flexible" civil standard of proof. The passages from the Shipman report quoted above suggest that a broader approach was taken; Dame Janet explicitly said she would not be constrained by the requirements of "any one" standard of proof.

95 Looking at the overall effect of how previous inquiries have approached the matter, together with the current Inquiries Act and Inquiry Rules, the following principles may be gleaned:

- It is for the chairman of the inquiry to decide on the approach to be taken to findings of fact, criticism and recommendations as part of his role in determining the procedure of the inquiry.
- Even in inquiries which have to address allegations of extremely serious crimes, there is no place for the application of the criminal standard of proof.
- The context of the task set for the inquiry is important in deciding what the proper approach to making findings may be.
- An inquiry should not be inhibited from setting out its findings and opinions based on those findings by adherence to particular standards of proof.
- An inquiry is free to express its findings as it sees fit, provided that they are logically founded on the evidence, the basis of the finding is made clear, and a person adversely affected by a finding has had a fair opportunity to deal with it.

96 While the present Inquiry concerns events which had caused untold distress to many patients and their families and considerable public concern about the standard of service in our hospitals, it is not an investigation into the alleged commission of criminal offences. It concerns the apparent deficiencies in a system which allowed poor care and treatment to be given which may have caused harm to numbers of patients. Inevitably, it is likely that large numbers of individuals had a part to play in this, none of whom individually could have prevented the totality of what occurred. In the course of analysing what happened and why, inevitably, it will be necessary to consider what could have been done better by individuals and organisations. This is a necessary part of identifying the lessons to be drawn.

97 One other important difference between this Inquiry and the others is that its Terms of Reference require it:

> *where appropriate to build on the evidence given to the first inquiry and its conclusions, without duplicating the investigation already carried out.*

98 Therefore, the Inquiry is required, where it considers it appropriate, to proceed on the basis of evidence already given and conclusions reached in a previously published report written by the same chairman.

99 As already stated, no findings of fact or criticism made in this report are determinative of any form of civil or criminal liability. The duty of the Inquiry is to set out its conclusions about what happened, along with any observations it may have on what happened by way of comment or criticism and to offer what in its opinion are relevant recommendations. It should not be inhibited from doing so by reason of any particular standard of proof. It must, however, only make comments and criticisms which it concludes are fair, and should not do so unless those affected by criticism have had a fair opportunity to deal with it through the Rule 13 process.

100 Taking all these considerations into account, I have concluded that:

- The Inquiry should make findings based on the evidence before it, taking into account the findings of the first inquiry. In all instances, the Inquiry's findings must be guided by what is fair.
- Much evidence of what happened has not been contradicted. Where such evidence is not contradicted the Inquiry is likely to accept it unless it is inherently improbable, in which case this will be made clear.
- Where there are issues in relation to what happened, all the evidence relevant to that issue will be considered and taken into account. No particular standard of proof will be applied, but the Inquiry will find the facts on the basis of the evidence that it has preferred. A common sense approach will be adopted whereby inherently improbable assertions will be regarded with more caution than inherently likely ones.
- Where it is decided in relation to an important event that it is only possible to say it may have occurred, this will be made clear. The narrative of the report will make clear what the Inquiry has concluded occurred and will refer to evidence supporting that conclusion. As this is a report not a court judgment, a full account of the reasons for preferring the evidence cited will not always be given.
- Although there are no strict rules of evidence other than the overriding requirement of fairness, I will bear in mind that different weight may have to be afforded to different types of evidence.
- Criticisms of organisations and individuals may appear either in the course of a narrative account of what happened or separately. They may either be made explicitly or be implied. Where a criticism is made or implied, this will be the result of the Inquiry forming an adverse opinion arising out of the finding of fact. That opinion and the resulting criticism are a matter of judgement and not a matter for which proof is required. An explanation of the significance of criticisms in this report appears below.

Responsibility and criticism

Procedure

101 Where the inclusion of a significant potential criticism of an individual or organisation was being considered by me, they were notified of this under Rule 13 of the Inquiry Rules 2006 and offered an opportunity to respond. The notice was accompanied by a schedule prepared by Counsel to the Inquiry summarising the nature of the criticism and giving references to the evidence thought to support such a criticism. The Inquiry Rules 2006 provide that a duty of confidentiality is owed by the Inquiry and the recipients of such notices to each other in respect of such notices. This means that each has a duty not to disclose the existence of or content of the notice without the permission of the other. Recipients were invited to apply to the Inquiry for a waiver permitting them to share notices with those from whom they wished to receive assistance in formulating their replies. A large number of such applications were made and almost all granted on condition that the third parties signed a form of undertaking to maintain the confidence.

102 The requirements of Rule 13 of the Inquiry Rules 2006 are such that sharing large extracts from the draft report would have been impracticable, distracting and undesirable. This had the unfortunate result that some potential criticism had the appearance of being more severe than was in fact the case once the criticism is seen in its context. Likewise some recipients were concerned that they may have been singled out for criticism that could equally apply to others, not knowing that similar notices had been sent to others.

103 Some of the recipients had not given evidence to the Inquiry and had not been asked to. A particular group in this category were former Ministers; in their case, notices were served at the specific suggestion of the DH, which considered that some proposed criticisms were in fact criticisms of them. I had not previously been of the view that these criticisms were of Ministers for the reasons given below. Having considered the helpful responses I received from former Ministers, I remain of that view.

104 Some recipients of notices, both among those who had given evidence and those who had not, complained that the matter of criticism had not been put to them during the hearing and therefore they had not had an opportunity to respond to it. This indicated a failure to understand the purpose of the Rule 13 process, which is to provide a very specific and fair opportunity to individuals and organisations to respond to proposed criticism. The process has demonstrated its value in this Inquiry. I received many thoughtful and well constructed responses offering an analysis of the evidence, and in some cases new evidence, relevant to potential criticisms. I paid very careful attention to all the responses and have taken them fully into account in my final conclusions. Many modifications were made to the draft report as a result.

105 Some recipients asked that they be given sight of any revision of the potential criticism before publication of the Inquiry report. I declined to do so; first because the Rules do not provide for such a facility, and second because it would have been impracticable and undesirable. Such a process would inevitably have led to a virtually endless exchange of drafts and submissions, making the Inquiry process even longer than it already had been. For better or for worse, it is I who have been charged with the task of assessing the evidence and drawing my conclusions and that is a task I must complete with fairness, due care, and within as reasonable a timescale as possible. Any new evidence taken in to account in this way has been published on the Inquiry website.

General observations

106 There is a tendency when a disaster strikes to try to seek out someone who can be blamed for what occurred, and a public expectation that those held responsible will be held to account. All too frequently there are insufficient mechanisms for this to be done effectively. A public inquiry is not a vehicle which is capable of fulfilling this purpose except in the limited sense of being able to require individuals and organisations to give an explanation for their actions or inaction.

107 The evidence to this Inquiry has shown that we have still not managed to move successfully away from the culture of blame which Professor Sir Liam Donaldson, in *Organisation with a Memory,*[25] and Professor Sir Ian Kennedy, in the report of the Bristol Inquiry,[26] were so keen to banish. The understandable human need to identify one or more people to be held to account means that whenever something goes wrong a hunt starts, and the larger the disaster the more pressure there is. Thus a factor in the pressure leading to this Inquiry was a wish to see people brought to account, whereas if an inquiry is to fulfil its main purpose it has to identify lessons to be applied.

108 On the whole, the purpose of identifying where individuals have fallen below relevant standards should be to show examples of conduct or judgements to be avoided in future. In a system failure as widespread as that identified in this Inquiry, it becomes a futile exercise to undertake; so many are in one sense accountable, it is far more effective to learn rather than to punish. To place too much emphasis on individual blame is to risk perpetuating the illusion that removal of particular individuals is all that is necessary. That is certainly not the case here. To focus, therefore, on blame will perpetuate the cycle of defensiveness, concealment, lessons not being identified and further harm.

25 LD/5 WS0000070414–5
26 The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984–1995: Learning from Bristol (July 2001) The Bristol Royal Infirmary Inquiry

Approach to criticism in this report

109 It must be remembered that the inquiry mechanism is not equipped to determine individual responsibility by way of anything akin to a "trial". Individuals and organisations may be called to provide evidence, may have legal representation and may have the opportunity to respond in accordance with the Inquiry Rules 2006 and procedure to potential criticisms, but they cannot defend themselves as they could in adversarial proceedings – by cross-examination of critical witnesses, or presentation of evidence they choose to call in their defence – and they only have a limited right to make representations to the Inquiry. An Inquiry does not and cannot determine civil or criminal liability. Therefore, where comments or conclusions are made which are or might be interpreted as being critical of individuals, these serious limitations arising out of the nature of the process must be borne in mind.

110 This Inquiry is charged to investigate the deficiencies in the system which allowed the events of Mid Staffordshire to pass unnoticed or without effective reaction for so long. This is not a case where it was ever going to be possible or permissible to find that an individual or a group of individuals was to blame for this. When examining what went wrong in the case of a systems failure as complex as that surrounding the events in Stafford, the temptation of offering up scapegoats is a dangerous one which must be resisted. To do this would be to create the fiction that the behaviour of one person, or a small group of people, would have made all the difference and conclude that the easy answer to the problem is to appoint better performing individuals. It was not a single rogue healthcare professional who delivered poor care in Stafford, or a single manager who ignored patient safety, who caused the extensive failure which has been identified. There was a combination of factors, of deficiencies throughout the complexity that is the NHS, which produced the vacuum in which the running of the Trust was allowed to deteriorate.

111 The principal factors concluded to have been involved in this systems failure are examined in the chapters of the report. It has been necessary to examine particular examples of performance of individuals and organisations to demonstrate the conclusions. Such conclusions have been arrived at after consideration of all the evidence before the Inquiry, including responses to warnings issued under Rule 13 of the Inquiry Rules 2006. It is not practical or proportionate, even in a report of this length, to recite all the evidence relevant to every point, but to the extent appropriate to the matters considered the evidential basis for those conclusions is made clear in the text. Other evidence could often have been identified. In many cases where critical comment is made, examples of others acting in a similar fashion could often have been found. The unpalatable truth is that there is much for all who work in healthcare to learn from the narrative in this report in terms of reflecting on their own work, attitudes and collective culture.

112 Therefore, critical comments will be made about individuals and organisations, policies and cultures. It is extremely important that these are seen with these matters in mind. Much will

be said about culture in the report. Individuals and indeed organisations acting in accordance with a culture, even a negative or unhealthy one, cannot always be held personally responsible for doing so.

113 The most important task of an inquiry such as this is to identify the lessons to be learned. Such lessons can include, and they do in the report, ways in which particular matters of administration, management, or implementation of policy could have been done better. Such points can be and often are illustrated by reference to the activities of particular individuals. Such a narrative may appear to be critical of the individuals or organisations concerned, but unless the context specifically states to the contrary, it should be borne in mind that the report is written with the benefit of hindsight, in full knowledge of the appalling care provided at the Trust and an appreciation of its consequences for patients. A statement in the report that something might or should have been done differently is not in itself a suggestion of negligence or of a breach of a duty existing at the time. Such critical comment is not intended, unless the contrary is clear from the context, to suggest that many others would not have acted in the same way if presented with the same set of circumstances at the time.

114 The fact that a critical comment is made about some action of an individual or an organisation does not necessarily mean that there are not many positive aspects to their work and contribution to healthcare. Many of those about whom some critical comment has been made have been involved in making significant changes for the better. Many have offered notable insight to the Inquiry, and have evidenced a genuine desire to effect improvements in the service and the system providing it, often through thoughtful contributions about possible changes for the future. This makes it all the more important for the report to be read as a whole. What are perceived to be critical comments should not be taken out of context or in isolation from the rest of the report. In an inquiry required to focus on what went wrong and what needs to be changed it is simply inappropriate to qualify every critical comment with a reference to unrelated positive points. It is the unhappy task of an inquiry to focus on what went wrong, and not on what went right.

115 The report also contains more general observations about the effect of certain policies and their implementation. If there is one central message to emerge from this Inquiry it is that the safety of patients and the requirements of fundamental standards are obligations which need to transcend particular policies and to permeate all considerations within the system. Nothing in this report is meant to question or analyse the wisdom or appropriateness of individual policies, ranging from the creation of the FT concept through to the Coalition Government's present reforms. It is not intended to suggest that any Government or any Secretary of State for Health, or any of their junior Ministers did not intend to maintain standards of safety and minimum care. Clearly there are many different ways in which healthcare can be delivered to the public, and it is well beyond the remit of this Inquiry to debate the respective merits of the various approaches taken by different Governments. It is in any event unrealistic to lay personally at the door of Ministers responsibility for the detail of ensuring that the implementation of a policy does not prejudice safety or effective delivery of minimum standards, unless they have received advice on that subject which they ignore. The DH is a remarkable combination of policy making, administration and executive NHS management, which makes recognition of the reality of the practical limits of Ministerial responsibility important, whatever may be the constitutional theory.

The structure and style of the main report

116 Given the complexity of the system, it has been the task of the Inquiry to examine the overlapping functions of the various organisations within it, and there has been no single obvious way in which to structure the main report. The approach taken has been to start with a consideration of warning signs (*Chapter 1: Warning signs*) that in retrospect existed and could have suggested that the Trust was the subject of serious deficiencies in relation to the provision of a safe and effective service. This chapter seeks to proceed in roughly chronological order, but, where a strict date order of events might not assist, some themes are pursued as a whole.

117 The report then proceeds to pick out some matters concerning the governance and culture of the Trust. It must be emphasised that this is not intended to be a comprehensive examination of all that went wrong there: this report must be read with the report of the first inquiry and the report of the HCC for a full understanding of that.

118 There follows an examination of the role played by local scrutiny and patient and public involvement groups, the commissioners, the SHA, and the regulators with a view to establishing what went wrong, followed by a consideration of the involvement of other agencies.

119 Finally, there follows a section dealing with themes for the present and future, arising out of what went wrong.

120 Of necessity, some events and evidence are referred to in more than one chapter. While an attempt has been made to keep repetition to a minimum, it is necessary in some contexts to assist in understanding.

121 Evidential references are given for all statements of fact and quotations in the report. Further detail as to the format of references used in this report appears on the Inquiry's website. In general unless the context makes the contrary clear, I have accepted the evidence recited. While I have had regard to all the evidence admitted and the submissions made, this already long report would have been unmanageable if all evidence relevant to each point were recited or referenced or if a fully reasoned decision was given for each issue of fact requiring determination. On the few occasions where there have been significant disputes about fact I have sought to give a fuller analysis for my conclusion. It is important when considering my recitation of facts, comments, criticisms and conclusions to read them in context, just as the report must be read as a whole.