

## Learning from mistakes

An investigation report by the Parliamentary and Health Service Ombudsman into how the NHS failed to properly investigate the death of a three-year old child



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Presented to Parliament pursuant to Section 14(4)(b)  
of the Health Service Commissioners Act 1993

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# Contents

Foreword	2
Chapter 1: Summary and insight	3
Chapter 2	9
Introduction	9
What happened to Sam	10
The purpose of our second investigation	11
Our statutory role and how we consider complaints	11
The scope of the complaint we investigated	12
How we conducted this investigation	13
Chapter 3	14
The facts	14
Our findings	28
Injustice	42
Our recommendations	43
Chapter 4: What we have learned from the Morrish family's complaints	45
Annex A – The relevant standards	50
Annex B – Observations on the Child Death Overview Panel Process	51

## Foreword

I am laying this report before Parliament under section 14(4)(b) of the *Health Service Commissioners Act 1993*.

This report is about a family finally being given answers as to why the NHS failed to uncover that their son's death was avoidable.

Sam Morrish, a three-year-old boy, died from sepsis on 23 December 2010.

Our 2014 investigation found that had Sam received appropriate care and treatment, he would have survived.

Yet, previous NHS investigations failed to uncover that his death was avoidable. So the family asked us to undertake a second investigation to find out why the NHS was unable to give them the answers they deserved after the tragic death of their son.

Our second investigation found that the local NHS investigation processes were not fit for purpose, they were not sufficiently independent, inquisitive, open or transparent, properly focused on learning, or able to span organisational and hierarchical barriers, and they excluded the family and junior staff in the process.

Had the investigations been proper at the start, it would not have been necessary for the family to pursue a complaint. Rather, they would, and should, have been provided with clear and honest answers at the outset for the failures in care and would have been spared the hugely difficult process that they have gone through in order to obtain the answers they deserved. As a result, service and investigation improvements were also delayed.

We hope that this case acts as a wake-up call to drive through much-needed improvements in how the NHS investigates complaints about potential avoidable harm or death. Our report highlights two key areas for focus.

Firstly, the NHS needs to build a culture that gives staff and organisations the confidence to find out if and why something went wrong and learn from it.

Secondly, complaints about avoidable harm and death need to be investigated thoroughly, transparently and fairly by the NHS, to make service improvements possible. Sadly the experience of this family is not unique. Time and time again we find that the NHS' investigations are not consistent, reliable, or good enough.

I would like to thank the family for pursuing the complaint, which has important lessons for both the NHS and for our own organisation.

Dame Julie Mellor, DBE  
Chair and Ombudsman  
**Parliamentary and Health Service  
Ombudsman**

July 2016

# Chapter 1: Summary and insight

## 1. Introduction

Mr and Mrs Morrish complained to us in 2012 about the care and treatment provided to their son Sam by a GP Surgery, NHS Direct, Devon Doctors and an NHS Trust. They also complained about how those organisations, and the local Primary Care Trust, investigated what happened to Sam.

In our first investigation report we upheld Mr and Mrs Morrish's complaints. We found failures on the part of every organisation involved in the care that they provided to the family. We found that, were it not for the failures we identified, Sam would have lived. We also found failures in the way that the organisations involved dealt with Mr and Mrs Morrish's complaints about the care provided to Sam.

Mr and Mrs Morrish welcomed our findings, however, they had also always wanted us to ask why the failings had occurred in Sam's treatment, and why the subsequent investigations conducted locally had failed to conclude that Sam's death was avoidable. As a result, we agreed to undertake a second investigation in order to establish 'how' and 'why' the organisations involved failed to identify that Sam's death was avoidable and to explore the lessons for the wider NHS.

We also agreed to look at the mismatch between the family's expectations of us and what we delivered in our first investigation. We

have considered how the family's experience of our service has impacted on how we go about our work and how our work contributes to an increase in wider learning in the NHS.

Mr and Mrs Morrish have pursued their complaints for so long because they want NHS organisations to understand when mistakes are made in order to learn from them and improve. This learning depends upon the NHS recognising when an incident of potentially avoidable harm has occurred and having the right skills and experience to investigate it robustly.

We know the NHS currently has a significant problem with the quality of investigations into avoidable harm and there have been a number of published reports on the subject recently including:

- NHS England's recent review of maternity services which found a lack of consistency in the standard of local investigations.
- A 2015 study by the Royal College of Obstetricians and Gynaecologists which found that over a quarter of investigations into problems during labour were of poor quality.
- The review of unexpected deaths at Southern Health Trust.<sup>1</sup>
- Our own report, published in December 2015, on the quality of NHS investigations found that 40% of investigations were not adequate at finding out what had happened.
- CQC briefing: Learning from serious incidents in NHS acute hospitals identified five significant areas for improvement<sup>2</sup>

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<sup>1</sup> Mazars (2015) *Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015*. Available at: <https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/12/mazars-rep.pdf>

<sup>2</sup> Care Quality Commission (2016) *BRIEFING: Learning from serious incidents in NHS acute hospitals. A review of the quality of investigation reports*. June 2016. Available at: [http://www.cqc.org.uk/sites/default/files/20160608\\_learning\\_from\\_harm\\_briefing\\_paper.pdf](http://www.cqc.org.uk/sites/default/files/20160608_learning_from_harm_briefing_paper.pdf)

The Secretary of State for Health has recognised that NHS hospitals need ‘to feel interested in what happened, and should set up structures where independent investigations can be made into any avoidable harm’

## 2. Public trust depends on accountability, not blame

Public trust and confidence in services depends in part on accountability for improvements in service and safety that have resulted from learning from investigations and complaints.

We think, in relation to complaints of potential avoidable harm, demonstrating accountability includes three vital steps:

- i. Being willing to accept your own initial view might not be right and to ask open questions as an individual and as an organisation about what happened. In other words to do a proper investigation that involves all staff who provided diagnosis, care and treatment and the patient or their family. Providing staff and patients (and their families) with an honest explanation of what happened and why;
- ii. Learning from the investigation and taking steps to improve the service;
- iii. In the longer term providing evidence of performance against that expected as a result of the improvements being made – being able to assure the service leaders and the public that the service has improved.

If a service or group of services cannot pass the first test, as in this case, then it is impossible to learn, take action and measure performance improvements as a result. Instilling a willingness to ask questions and be curious as to other potential explanations for potential serious incidents should be the aim to help families, staff and services when such things happen.

The family who brought this complaint to us have told us that they have pursued their complaints for over 5 years to encourage NHS organisations to get the first step right so that they can learn and improve safety when mistakes are acknowledged and learnt from. They want staff to understand what happened and why and be able to learn so that services can be made safer. They want the learning from this case to be used by other health service providers and the NHS as a whole as a catalyst for wider improvement.

## 3. Culture and competence

This case, like so many others, shows that organisations were not competent in the way they investigated this serious complaint and that this incompetence went unchallenged. Why? There is plenty of evidence and insight across the NHS that fear of blame drives defensive responses. This may have been the case here.

For NHS organisations and staff to be confident to get to the bottom of what happened requires the building of a culture of positive accountability to find out and understand if something did go wrong and where it did to determine whether human error, system failure or a combination of the two lay behind mistakes. There is a need to work towards ending the fear of punitive responses and reputational damage being an immediate consequence of openly accepting that an error may have occurred.



This need is well articulated by one of those tasked by the NHS to investigate the Morrish family's concerns – a Chief Executive of a neighbouring NHS Trust. When we interviewed the Chief Executive he said:

*'The "why" question I wish to raise is in relation to our investigation processes in complex cases, when a series of things seems to have gone wrong.*

*'Why do we not have coherent and consistent investigation processes? In this Trust we have introduced a "Patient Safety Team". Its role is to investigate serious incidents quickly, consistently and thoroughly, involving family, carers, staff, etc. It is still in its infancy but is based on the notion of an air accident investigation team.*

*'In the case of Sam, this was a complex case and arguably a preventable death. It was immediately evident that there had been multiple factors relating to Sam's illness and ultimate death. In such a serious case, where learning is critical in trying to prevent future deaths of this nature, I believe we should have expert investigation teams that can investigate thoroughly, rapidly, consistently and without prejudice. Not seeking to purchase blame but to understand what went wrong and to determine whether human error, system failure or a combination of the two. A series of clear actions and recommendations should be published and implemented.*

*'The current system, certainly in some parts of the NHS, relies on current staff who are not experienced in investigations to carry out what can be very complex investigations. I believe it is critical to ensure we have trained and experienced investigators working to consistently high standards to ensure*

*learning and improvement, to give the public confidence in the thoroughness of investigation and to ensure changes are made as a result.*

*'If I was the Ombudsman or the Secretary of State, I would be asking why we do not have rapid, consistent and thorough investigations into cases as complex as Sam's.'*

This shift towards a more positive culture will drive both the development and embedding of organisational competence to investigate, learn and improve and the confidence to challenge the lack of it.

Again, this is what the family say they want to see happen. They have been extraordinarily generous spirited and consistent in articulating the lack of psychological safety felt by staff when they fear or experience blame, or a lack of involvement or a lack of support to get things right. They view this as an injustice experienced by staff involved in serious incidents as well as families.

Below we describe the mistakes and missteps in the process of investigating the reasons for Sam Morrish's death and handling the resulting concerns of the family. We then describe some recommendations for the NHS which needs urgently to tackle both technical competence and culture.

#### 4. Findings

Mr and Mrs Morrish complained that the NHS investigation processes are not fit for purpose, believing that they are not sufficiently independent, inquisitive, open or transparent, properly focused on learning, or able to span organisational and hierarchical barriers, and that they exclude patients, their families, and junior staff in the process. In relation to the investigations undertaken after Sam's death, we agree.

We have upheld the complaints put to us by the family about every organisation that investigated aspects of Sam's care. We have found that those involved were not always suitably independent and that the organisations failed to co-ordinate and cooperate sufficiently with one another. We have identified a failure to obtain appropriate information, a lack of timely statements being taken as part of any formal process and a lack of appropriate (and in some cases any) involvement and communication with both the family and the staff.

The organisations made no clear attempt collectively to seek to identify lessons from this case. Without a proper investigation into the events that took place, involving the staff and the family, there was no possibility of learning (locally or nationally) or action being taken to avoid such incidents in the future. Had the investigations into Sam's death been proper at the start, it would not have been necessary for the family to pursue a complaint.

Mr and Mrs Morrish have asked us if we have found any evidence that the organisations tried to 'cover up' the failures in Sam's care. We have not found any such evidence. Rather, we believe a fundamental failure in this case was the organisations - in particular the Trust – total unwillingness to accept that no view other than their own was the right one. Those involved appeared to accept almost immediately the view that Sam's death was rare and unfortunate rather than being open to other possibilities and, in doing so, asking open questions as part of a proper investigation that involved staff and the family. This was coupled with a general failure to accept that the questions the family were asking might have been reasonable ones.

In particular, we note the PCT's role and the opportunity it had to look holistically at the failures of all organisations involved. We have found that the PCT failed to ensure that the organisations involved in Sam's care were aware of his death and the need to investigate it fully and appropriately. The organisations involved did not work together and undertake one effective investigation. We have found that this was, in part, down to the failure of the PCT to properly and effectively co-ordinate the investigations as recommended in such circumstances by the NHS complaints regulations.

Had the PCT acted properly, and considered clearly and effectively what the organisations had done compared to what they should have done, they would have identified at least some of the learning that we have identified in this (and our earlier) report. We note that some of the organisations involved were seemingly dependent on the PCT for information about the investigations and communication with the family. Although it is correct to say that the PCT had a key role in coordination and communication, we think it should have been clear to the other organisations involved that this process wasn't working for the family. In the absence of effective coordination by the PCT, the organisations involved should have done more to communicate properly and clearly with the family.

Most importantly for the family, the organisations involved locally made no clear attempt to seek continuous improvement and identify lessons from this case together.

Further detail on our findings is in chapter 3.

## 5. Our accountability

Following the publication of our first report and our decision to undertake a second investigation, we agreed to look at how we handled Mr and Mrs Morrish's first complaint so that we could learn from their experience and consider how that learning might inform our work in future. We are part way through a very significant modernisation of our service and so we have been able to build the learning from the family's feedback into that process. As such, the family's experience has fed into both our service improvements and how we have developed our role in order to maximise the insight from complaints and feed the learning back to service providers for improvement.

Further detail on our learning is in chapter 4

## 6. Conclusion and recommendations

As we highlighted at the beginning of this chapter, the findings in this case are common. Many NHS providers and commissioners will identify with elements of our findings.

### *Competence*

We concur with the five areas for improvement identified by the recent CQC Briefing: Learning from serious incidents in NHS acute hospitals<sup>3</sup> :

1. Serious incidents that require full investigation should be prioritised and alternative methods for managing and learning from other types of incident should be developed.
2. Patients and families should be routinely involved in investigations.

3. Staff involved in the incident and investigation process should be engaged and supported.
4. Using skilled analysis to move the focus of investigation from the acts or omissions of staff, to identifying the underlying causes of the incident.
5. Using human factors principles to develop solutions that reduce the risk of the same incidents happening again.

There are also improvements to be made in communication, co-ordination and governance within and across organisations.

As we noted in our report into *the quality of NHS complaints investigations where serious or avoidable harm has been alleged*<sup>4</sup> we recommend training and accrediting sufficient investigators to operate locally. We also believe there is a need for the role of NHS complaint managers and investigators to be better recognised, valued and supported.

We welcome the role that Healthcare Safety Investigation Branch (HSIB) will play in developing and promoting best practice to take this agenda forward.

### *Culture*

The impact of actions to improve competence will be limited without a parallel focus, locally and nationally, on creating a just culture. Tackling the current defensive culture and fear of blame requires soul searching and bravery at every level from politicians to system leaders, organisational leaders, clinical leaders and front line staff.

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<sup>3</sup> Care Quality Commission (2016) BRIEFING: Learning from serious incidents in NHS acute hospitals. A review of the quality of investigation reports. June 2016. Available at: [http://www.cqc.org.uk/sites/default/files/20160608\\_learning\\_from\\_harm\\_briefing\\_paper.pdf](http://www.cqc.org.uk/sites/default/files/20160608_learning_from_harm_briefing_paper.pdf)

<sup>4</sup> Parliamentary and Health Service Ombudsman, A review into the quality of NHS complaints investigations where serious or avoidable harm has been alleged, December 2015. Available at: <http://www.ombudsman.org.uk/reports-and-consultations/reports/health/a-review-into-the-quality-of-nhs-complaints-investigations-where-serious-or-avoidable-harm-has-been-alleged>

The focus on a 'safe space' for the investigations of the new Healthcare Safety Investigation Branch (HSIB) is absolutely a step in the right direction. However, all but a very small number of investigations will continue to be conducted locally, just like this one. Now is the time for the NHS to build on the momentum started by the creation of HSIB and explore how it can give staff across the NHS the confidence to be open to exploring what happened so that, if mistakes were made, they can learn and improve safety for others in future.

We recommend that NHS system leaders (including NHS Improvement, NHS England, Department of Health and CQC) consider how they can provide collective and collaborative leadership to create a positive, no blame culture in which leaders and staff in every NHS organisation feel confident to openly investigate and report, learn and improve patient safety.

# Chapter 2

## Introduction

1. Mr and Mrs Morrish complained to us in April 2012 about the care provided to their son, Sam, by the Cricketfield Medical Centre, Devon Doctors, NHS Direct and South Devon NHS Foundation Trust. They complained that the inadequate care and treatment provided to Sam had led to his death. They also complained about how the organisations involved had handled their subsequent complaints. We investigated their complaint and upheld it. We concluded that Sam's death had been avoidable. We published our report of our investigation in June 2014, recommending an apology from all of the organisations and the payment of a financial remedy. We also made wider recommendations intended to address the failures we had identified.
2. Mr and Mrs Morrish welcomed our findings but felt that our investigation had not gone far enough. They told us that they were still left asking why the failings had occurred in Sam's treatment, and why the subsequent investigations conducted locally had failed to conclude that Sam's death was avoidable. They said they believed a key feature in any complaint investigation should be consulting with patients and their families, and that organisations involved must listen to, and act upon, any concerns raised. They told us they felt the primary aim of any such enquiry should be to find out what had happened, and how and why failures had occurred so that lessons can be learned and changes made. Mr Morrish wrote:

*'... The result of the Ombudsman's enquiry is contained in a report issued by them and that report goes some way to answering the questions and concerns I had but I still have issues that need to be addressed.*

*I am not complaining specifically about what did or didn't happen to Sam because that has happened and been covered. It's all about how the NHS was able to draw the wrong conclusion and reassure itself that Sam couldn't be saved, despite the fact they were being asked questions which should have helped them actually think a bit harder.'*

3. We agreed to carry out a second investigation to explore further Mr and Mrs Morrish's complaint that the investigations into Sam's death by the organisations involved were inadequate. As part of that investigation we have considered the importance of investigations into serious incidents being undertaken fairly, effectively, compassionately and inclusively in the best interests of patients, families, staff and identifying wider learning. We also agreed to consider what we as an organisation could learn from our handling of Mr and Mrs Morrish's earlier complaint.

## What happened to Sam

4. Sam (aged three) became unwell during a flu epidemic in December 2010. He had been ill for about a week when a GP at the Surgery saw him on 21 December. The GP sent him home with a prescription for antibiotics to take just in case he developed an infection.
5. On 22 December, Sam's condition continued to cause concern and Mrs Morrish returned to the GP who assessed him and sent him home with some cough syrup. Sam's condition continued to deteriorate and he vomited later that evening. Mrs Morrish contacted NHS Direct and a Nurse Advisor assessed Sam's condition over the phone. She referred Sam to Devon Doctors, an out-of-hours GP service.
6. A GP from Devon Doctors subsequently called the Morrish family home but there was no answer. Mrs Morrish called them a couple of hours later. The call handler contacted Newton Abbot Treatment Centre and spoke to a member of staff (who was not clinically trained). Following discussion with the staff member, the call handler told Mrs Morrish to take Sam to see an out-of-hours GP at Newton Abbot Treatment Centre.
7. When Mrs Morrish arrived at the Treatment Centre she was asked to wait. Around 20 minutes later a minor injury unit nurse walked past Sam and Mrs Morrish alerted her to his condition. The nurse took Sam into a resuscitation room for treatment where he was seen by a doctor who immediately arranged for him to be transferred by ambulance to Torbay Hospital, part of the Trust.
8. A Paediatric Registrar at the Trust saw Sam and prescribed him antibiotics and fluid for pneumonia. The antibiotics were not administered for two to three hours. Due to the severity of his condition, Sam was admitted to the paediatric high dependency unit but he deteriorated further and died early in the morning of 23 December.
9. Following Sam's death, Mr and Mrs Morrish met with GPs from the Surgery and the Paediatric Consultant at the Trust to find out why Sam died. The Primary Care Trust (PCT) began a root cause analysis<sup>5</sup> into the circumstances around Sam's death. Mr and Mrs Morrish were unhappy with the findings of the root cause analysis and the PCT commissioned an independent investigation into their complaints. It is accepted that this second investigation did not meet all of the intended objectives, and as such it did not address all of the family's concerns. Fundamentally, it failed to give a definitive answer as to whether earlier treatment would have saved Sam's life.
10. A third investigation was offered to the family but, understandably, they lacked confidence in the NHS complaints process. In April 2012 the family asked us to investigate the matter. We accepted the complaint for investigation in August 2012.
11. Our first investigation report, published in 2014, found service failure in almost every aspect of the care provided for Sam. We found that, had Sam received appropriate treatment, he would have lived. We also found maladministration in the way the organisations had dealt with the family's subsequent complaints and requests for information.

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<sup>5</sup> A root cause analysis is a method of problem solving used for identifying why faults or problems happened.

12. We also found maladministration in relation to every organisation involved, in their attempts to investigate the concern raised by Sam's family. Amongst other things, we identified failures in communication, poor explanations and a failure to understand the heart of Mr and Mrs Morrish's complaints.

## The purpose of our second investigation

13. In this investigation we have looked further into how the organisations conducted their investigations following Sam's death to find out why they failed to identify the failures we found in the treatment Sam received and, most importantly, why they were unable to identify that Sam's death was avoidable.
14. In this report we will highlight where the systems have failed, and where possible, identify how and why they failed. Specifically:
  - how organisations implemented, executed and governed their investigative procedures;
  - the gaps in those procedures and the consequences of those gaps;
  - communication between different health organisations and the co-ordination of cases that involve more than one organisation;
  - communication between those organisations and the family;
  - how failings early on in the investigative process, and assumptions made on the part of those investigating, affect conclusions made by subsequent reviews and investigations; and

- how the whole investigation process can be improved from start to finish for all organisations concerned in this case.

15. As part of this second investigation we also undertook to identify our own learning following our first investigation, to look at how we could have handled the family's complaint differently, and what we could do in the future to improve our service.

## Our statutory role and how we consider complaints

16. We make final decisions on complaints that have not been resolved by the NHS in England and UK government departments and some UK public organisations. We do this independently and impartially.
17. We are not part of government, the NHS in England or a regulator. We are neither a consumer champion nor arbitrator.
18. We look into complaints where an individual believes there has been injustice or hardship because an organisation has not acted properly or fairly, or has provided a poor service and not put things right. We normally expect people to complain to the organisation first so it has a chance to put things right. If an individual believes there is still a dispute about the complaint after an organisation has responded, they can ask us to look into the complaint.
19. We are the final stage for complaints about the NHS in England and some public services delivered by the UK Government.
20. We are accountable to Parliament and our work is scrutinised by the Public Administration and Constitutional Affairs Committee.

21. When considering a complaint we begin by comparing what happened with what should have happened. We consider the general principles of good administration that we think all organisations should follow. We also consider the relevant law and policies that the organisation should have followed at the time.
22. If the organisation's actions, or lack of them, were not in line with what they should have been doing, we decide whether that was serious enough to be maladministration or service failure. If we find that service failure or maladministration has resulted in an injustice, we will uphold the complaint. However, if we do not find that the injustice claimed has arisen from the service failure or maladministration we identified, we will only partly uphold the complaint. Alternatively, if we do not find service failure or maladministration then we will not uphold the complaint.
23. If we find an injustice that has not been put right, we will recommend action. Our recommendations might include asking the organisation to apologise, or to pay for any financial loss, inconvenience or worry caused. We might also recommend that the organisation takes action to stop the same mistakes happening again.

## The scope of the complaint we investigated

24. Mr and Mrs Morrish complain that despite internal investigations at the Surgery, Devon Doctors, NHS Direct, the Trust and the PCT, those organisations were able to draw the wrong conclusion and reassure themselves that Sam could not have been saved.
25. Mr and Mrs Morrish complain that the NHS independent investigation review processes are not fit for purpose, believing that they are not sufficiently independent, inquisitive, open or transparent, properly focused on learning, or able to span organisational and hierarchical barriers, and that they exclude patients, their families, and junior staff in the process. They point out specifically that clinicians who were either involved in providing or overseeing Sam's treatment had influence over [1] early investigations and [2] reaching the conclusion that Sam's death was unavoidable.
26. Mr and Mrs Morrish complain that in the absence of 'understanding' and 'learning' about 'how' and 'why' Sam's death was deemed unavoidable, investigations and complaint systems will continue to fail, exposing patients and staff to avoidable risk.



27. Mr and Mrs Morrish also complain that the Child Death Review process itself (and therefore the Child Death Overview Process / Panel) is fundamentally flawed and of unknown effectiveness. They believe it was mishandled in their case, citing the fact that a consultant responsible for Sam's care at South Devon Healthcare NHS Foundation Trust was allowed to chair the local Child Death Review meeting. They complain that the Child Death Review process accepted the NHS's conclusions that Sam's death was unavoidable whilst simultaneously excluding the family and ignoring or dismissing their concerns. They suggest it lacks impartiality, checks and balances, and meaningful or effective accountability, is not open or transparent in its approach or its findings, and that as a result it cannot reliably fulfil its purpose, which is to help reduce avoidable child deaths.
28. As a result of the way that the various organisations dealt with Mr and Mrs Morrish's complaint, they felt that whilst grieving and isolated they had to persistently challenge all relevant organisations, departments, processes and systems for a number of years, concerned by the apparent lack of ability or willingness to investigate, understand, or learn from Sam's unexpected death, in the hope of reducing additional avoidable deaths.

## How we conducted this investigation

29. Our investigation has been carried out by a team with dedicated roles and responsibilities. The team consisted of a senior investigator and two other members of staff who carried out specific functions. One a dedicated single point of contact for the family (the family liaison),

who also conducted enquiries, and the second, an investigator who reviewed the material gathered as part of our original investigation and conducted interviews with staff at the organisations involved in the case.

30. We interviewed a number of the health care professionals who were involved in Sam's care and treatment. We wanted to find out about the processes the organisations involved had in place for dealing with cases such as this, whether those organisations followed those processes and, if they had followed them, whether the processes were adequate. We sought to understand what information they had gathered after Sam's death up until the point the family referred the matter to us. We considered the standard of the investigations that had been undertaken locally alongside the policies and processes that were in place at the time. We also considered the standard of the local investigation in line with the *NHS Complaints Regulations 2009*, the *NHS Constitution*, and the *Ombudsman's Principles of Good Complaint Handling*, and web links to these documents can be found in Annex A.
31. We recorded the interviews we conducted and they have been transcribed as part of the evidence on which we are basing our findings and recommendations. We also considered again the significant amount of information we gathered during our first investigation. Most importantly, we worked with Sam's family to make sure that we had fully understood their concerns, their perspective and what they wanted to achieve.

## Chapter 3

### The facts

32. Our first report<sup>6</sup> sets out in detail the facts regarding the various NHS organisations' interactions with the Morrish family, both with regard to the care provided to Sam, and the way that they handled the family's subsequent complaints. We have included here some of the key events outlined in that report, as well as the further detailed information we have gathered as part of our second investigation.

### The Surgery

33. Following Sam's death on 23 December 2010, the Consultant Paediatrician in charge of Sam's care at Torbay Hospital informed the senior GP at the Surgery of Sam's death. The senior GP subsequently told staff at the Surgery. He told us that in the following days the doctors informally discussed the care they had provided.

34. Sam's death was formally discussed at a practice meeting on 7 January 2011. Staff at the Surgery agreed they did not know how to proceed with an appropriate investigation into Sam's care, and that they had no experience of dealing with an investigation of this importance. They agreed they would seek guidance from the PCT. Staff told us that as Sam had died at Torbay Hospital they expected the Trust to take the lead in any investigation.

35. After speaking with the PCT, the senior GP took the lead within the Surgery and became the point of contact for the family and other interested parties. Members of staff at the Surgery who had contact with Sam and his family prepared written accounts detailing their involvement. The GPs referred to Sam's medical records when making their statements.

36. The senior GP rang the family on 23 December 2010 and spoke with one of Sam's grandparents. He expressed his sympathy and offered any assistance the family required.

37. The Surgery had little experience of dealing with family bereavement and was aware that the Consultant Paediatrician, on behalf of the Trust, was in contact with the family. Our first investigation found that the doctors at the Surgery assumed the Trust was looking after the family's needs, although we noted that there was an open offer from the Surgery to provide assistance to the family.

38. On 18 January 2011 the Patient Safety Manager at the PCT informed the senior GP that she was conducting a root cause analysis involving all organisations in Sam's care. She said she would arrange a meeting for parties to discuss the case. The PCT requested a chronology of events relating to Sam's care, which the Surgery quickly completed. The senior GP told us that he understood that the purpose of the meeting was to establish what happened, whether anything went wrong, what could have been improved, and to identify learning for the future. He said he anticipated that someone from the PCT would interview the doctors at the Surgery as part of the root cause analysis.

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<sup>6</sup> Our report – *An avoidable death of a three-year old child from sepsis* can be found in full at [www.ombudsman.org.uk](http://www.ombudsman.org.uk).

39. On 25 January 2011 Mr and Mrs Morrish met with staff at the Surgery, including the senior GP. This meeting took place at the family's insistence. The family raised concerns about Sam's care at the Surgery, the contact the Surgery had made with the family after Sam's death and ongoing support that might be available for the family in the future.
40. On 27 January 2011 the senior GP had a further meeting with Mr and Mrs Morrish. At this meeting the family questioned the significance of the fact that Sam's nappy was dry at the second GP appointment. Mr Morrish told us that he had to ask four times about the relevance of the dry nappy before the senior GP accepted that this indicated dehydration in Sam and that such a significant fact should have been a '*red flag*' or a warning indicator for referring Sam to hospital.
41. On 4 April 2011 the senior GP attended the PCT's root cause analysis meeting on behalf of the Surgery. He was the only practising clinician present from the organisations involved in Sam's care.
43. On her return from leave the Clinical Governance Lead made immediate contact with the PCT and explained it was too short notice to complete a full report. She requested an internal preliminary review of Mrs Morrish's call with NHS Direct. This review indicated that the NHS Direct Nursing Advisor's referral to Devon Doctors should have been 'urgent' rather than 'routine'. The Clinical Governance Lead informed the PCT that she was unable to attend a meeting that had been arranged for 4 April but submitted a timeline to the meeting. She did not arrange for a deputy to attend.
44. On 5 April the Clinical Governance Lead requested a local management review of Mrs Morrish's call and the actions of the Health Advisor and the Nurse Advisor. The London Regional Clinical Governance Lead at NHS Direct completed the review and submitted it to NHS Direct's National Clinical Governance Team on 9 May. As part of her review she asked the line managers of the Health Advisor and the Nursing Advisor to review the call and complete a self assessment. She requested that the reviews be completed by 28 April. The reviews were not completed until 26 May.

## NHS Direct

42. As part of the PCT's investigation, NHS Direct was contacted by the Patient Safety Manager in March 2011. Between 9 and 21 March 2011 the Patient Safety Manager sent three emails to the South West Regional Clinical Governance Lead at NHS Direct relating to the root cause analysis investigation and requesting a timeline and a report of NHS Direct's involvement. These emails were not seen until the Clinical Governance Lead returned from leave on 30 March. There was an 'out of office' flag on her email account but no alternative contact details provided and no one was delegated to check the account in her absence.
45. In the meantime, on 12 April, the Clinical Governance Lead raised an Incident for National Review notification. This escalates the incident for national review rather than just a local review.

46. On 27 April the Trust invited the Clinical Governance Lead to attend the Child Death Review Meeting to be held on 4 May. The Clinical Governance Lead responded the following day, saying she was unable to attend due to prior commitments, and had been unable to arrange a deputy at short notice (29 April to 2 May 2011 was the Easter Bank Holiday weekend).
47. On 9 May Mr Morrish requested the voice recordings of the telephone calls Mrs Morrish had made to NHS Direct as well as the computer records they held. NHS Direct gave him this information on 18 May. On 24 May Mr Morrish contacted NHS Direct saying that he had listened to the recording and compared it to the Nursing Advisor's computer record. He said he had identified discrepancies between the audio and computer records.
48. On 3 June the Divisional Director of Nursing at NHS Direct chaired a National Peer Review meeting – a meeting to consider the local management review report that was established as part of the National Review notification being completed. On 9 June the Divisional Director of Nursing provided the family with a report on the findings of the National Peer Review meeting. Ten days later a panel reviewed and agreed the report of that meeting and it was approved by the Clinical Risk and Litigation Manager on 29 November. On 1 December 2011 it was published by NHS Direct.

## Devon Doctors

49. Devon Doctors became aware of Sam's death on the morning of 23 December 2010. It told us that one of its doctors was working at Torbay Hospital and attended a handover meeting at which the doctor was made aware that Sam had died.
50. Devon Doctors said it immediately reviewed its involvement in Sam's care. The review established that Devon Doctors received the call from NHS Direct at 6.45pm. Although the call was about an ill child, NHS Direct had not marked it as urgent. The review also established that Devon Doctors had tried to contact the family at 7.15pm but there was no reply, and no facility to leave a message. Its review found that this call back to the family was within the appropriate time frame of its working practice, and that nothing else happened until around 9.10pm. This raised the question for Devon Doctors as to why no further attempts to make contact with the family had been recorded. Devon Doctors did not know whether this was because the doctor had not tried to contact the family again or whether he had tried to make contact but had simply not documented it.

51. The on call doctor was not contacted immediately as part of Devon Doctors' review to provide his recollection of the call. Devon Doctors told us that it could be quite difficult for a doctor to remember such calls and what they did or did not do. As such the audit trail of the call is examined before any questions are asked. The information regarding the call was stored off site and this meant it took some time to access. Devon Doctors created a fresh record of the review on the paper based system it had at the time. This was updated to a computer based system in April 2011. No further action was taken by Devon Doctors. The review established that there was a delay in calling the family back.
52. Devon Doctors became aware of the PCT's involvement by chance and informed it that it had been involved in Sam's care due to a referral from NHS Direct. At that time the PCT believed that Sam had been taken direct to Newton Abbot Minor Injuries Unit and then referred to Torbay Hospital. In fact the out-of-hours GP service was based in the same building as Newton Abbot Minor Injuries Unit. The PCT subsequently asked Devon Doctors to provide a timeline, and attend the meeting that was being arranged regarding the root cause analysis.
53. As with the Surgery, Devon Doctors did not have much, if any, experience of being involved in a multi-agency root cause analysis inquiry. It was asked to produce a timeline but otherwise given no direction by the PCT. Devon Doctors believed that the information it gave to the PCT was being relayed to the family and expected information from the family to be fed back.
54. The family asked for the recordings of the telephone calls with Devon Doctors. These were provided by the Head of Governance for Devon Doctors who had delivered them. She told us that she had realised that it would be difficult for the family to listen to the calls, but that she had assumed the PCT had told the family about the content of the recordings. The family have told us their recollection is that the PCT did not have the recordings of the calls, and therefore could not have been aware of the contents or be in a position to pass this information on to them. When asked again about this point, Devon Doctors told us that it informed a meeting held by the PCT of the contents of the calls verbally. It accepts it did not hand a copy of the calls over to the PCT at that time and that it may well be the case that the family had received a copy of the calls before the PCT.
55. On 1 April 2011 the family produced a narrative of the events as they had experienced them, which raised questions for Devon Doctors. The PCT passed this to Devon Doctors. Devon Doctors answered the questions and fed the relevant information back to the PCT. At that time Devon Doctors did not communicate directly with the family.

56. The PCT's root cause analysis report was not signed off by Devon Doctors before it was released to the family. Devon Doctors conducted its own enquiries and prepared a report detailing its investigation. The family were provided with a version of that report in July 2011. The final version was signed off in December 2011 and the family have not seen this version. After reading the draft report the family felt that there were still issues to be addressed by Devon Doctors. Devon Doctors provided a written reply to the questions put to it but the family say that they have not yet been provided with those answers.

### Torbay and South Devon NHS Foundation Trust

57. At the time of Sam's admission to Torbay Hospital there was a national flu epidemic and there were 23 patients in the emergency department. In total, during the time Sam was in the emergency department, there were 30 other patients, 11 of whom were considered vulnerable due to their age (either because they were over the age of 70 or under the age of two). There were five nurses on duty at that time.

58. On arrival at Torbay Hospital Sam was taken to the resuscitation area within the emergency department. He was seen by the on duty Paediatric Registrar who recognised that Sam was very ill and required immediate resuscitation. He inserted a cannula into each of Sam's hands straight away and prescribed a fluid bolus<sup>7</sup>. As soon as the fluids were being administered he spoke to the Consultant

Paediatrician, who was at home at the time, but on call. He explained Sam's condition, the steps he had taken and discussed which antibiotics he intended to prescribe, and asked the Consultant Paediatrician to attend the emergency department. The Consultant Paediatrician arrived at the hospital within 10 minutes. An X-ray was ordered and a treatment plan decided.

59. Once Sam's care plan was agreed, the Paediatric Registrar made sure the nursing team was aware of what had been planned and what needed to be done. He said he spoke to a nurse and informed her he had prescribed antibiotics. He said to us that he expected them to be administered immediately. The Paediatric Registrar was new to the hospital and could not identify the nurse he spoke with. He recorded his findings and the drugs he had prescribed in the medical records at the time. He then attended to other patients.

60. The surgical team were called by the Paediatric Registrar, and reviewed Sam for the possibility of a stomach ulcer. Following their assessment of Sam they decided that his symptoms did not suggest an ulcer. The Consultant Paediatrician made his clinical assessment and decided to transfer Sam to the high dependency unit within the paediatric ward. The Paediatric Registrar told us that he believed it may have been better to send Sam to the intensive care unit immediately but that he deferred to the experience and knowledge of the Consultant Paediatrician<sup>8</sup>.

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<sup>7</sup> A process whereby fluids are rapidly delivered into a patient's vein in order to correct a life-threatening condition.

<sup>8</sup> In our 2014 report we found that the decision made to transfer Sam to the high dependency unit was appropriate based on the information available. However, we also found that the Trust should have sought further advice before taking this decision and that the information used to inform the decision was seriously flawed.

61. While he was in the emergency department Sam had a designated nurse who was with him all the time apart from a 15-minute break. She organised Sam's transfer to the paediatric high dependency unit. She said that this took some time to arrange and that just before Sam was about to be transferred, a doctor asked about Sam's X-ray, but she could not identify the doctor. The X-ray clearly showed that Sam had a congested right lung. The nurse said she had no knowledge of antibiotics being prescribed until the X-ray was reviewed. She said she recalled that a doctor asked if Sam had been given antibiotics. She said that the junior paediatric doctor said that the antibiotics would be administered following the transfer. She said that she was capable of administering antibiotics to children but, once she became aware of the requirement, doctors decided not to delay Sam's transfer to the paediatric high dependency unit by administering the antibiotics in the emergency department.
62. Staff at the Trust told us that the procedure for the administration of antibiotics to children is not as straightforward as for adults. In paediatric cases the dosage is calculated precisely based on the age and weight of the child. When such a calculation is made two nurses have to be in attendance, one to act as a 'safety-net' to check the calculations are correct. This has been verified by one of our independent clinical advisors.
63. Sam arrived on the paediatric ward high dependency unit at about 1am. Two paediatric nurses conducted initial tests and observations, reviewed Sam's notes and realised the antibiotics had not been given. They subsequently prepared and administered the drugs at 1.30am. Both nurses told us that they had expected the antibiotics to have been given in the emergency department. Neither nurse recalled prior contact from the emergency department informing them that they were to give Sam the antibiotics.
64. The nurse who took over Sam's care said that when she first saw him he appeared to be very, very unwell. She asked another nurse to assist her in reviewing Sam because she was concerned that he was so unwell. The second nurse said she realised that Sam had not had his antibiotics when she reviewed his notes that came with him from the emergency department.

65. The Consultant Paediatrician returned home once he was satisfied with the treatment plan put in place for Sam. He remained in contact with the hospital by telephone. He said he expected that Sam would be stabilised and started on a course of treatment that would treat his illness. He said that he recognised that Sam was very ill but did not believe that Sam's illness was so severe he would die. He was contacted by the Paediatric Registrar whilst at home regarding Sam's care and provided further instructions. Shortly afterwards he returned to the hospital to support the team caring for Sam. As he arrived on the high dependency ward in the early hours, Sam collapsed. Sam had been seen by the on call Consultant Anaesthetist, who consulted with the Intensive Trauma Unit Consultant about Sam's care when he was admitted. This was sometime after 1.30am. When Sam collapsed both the Consultant Anaesthetist and the Intensive Trauma Unit Consultant were present. Sam died early in the morning of 23 December 2010.
66. Sam's death was both sudden and unexpected. The Consultant Paediatrician informed the Coroner's office about Sam's death during the morning of 23 December and gave the cause of death. He told the Coroner there were no suspicious circumstances surrounding Sam's death and that he was willing to sign a death certificate. The cause of death was shown as '*hematemesis, septic shock and pneumonia*'. The Consultant Paediatrician did not know at this time that there had been a delay in administering the antibiotics prescribed in the emergency department, as he had not familiarised himself completely with the medical notes.
67. The Consultant Paediatrician had spoken with Mr and Mrs Morrish about Sam's condition while they were in the high dependency unit. He told us that he was not aware of the history of Sam's care in the community, other than that he had been unwell for a couple of days and his condition had worsened. The family do not agree with this and say that they had been asking staff at the Trust, including the Consultant Paediatrician, while they were at the hospital, how it was possible that Sam had become so seriously ill so quickly having been sent home by a GP earlier in the afternoon with cough medicine.
68. The Consultant Paediatrician said that although Sam's death was unexpected it could be explained. It is accepted that when he spoke with the Coroner's office he was not fully aware of the actions of the other NHS organisations involved in Sam's care. The Coroner decided that there was no need for an inquest. The Consultant Paediatrician also decided that there was no need for a rapid response team to be deployed as part of the Child Death Overview Process. He said he wanted a medical post mortem in order to try and establish exactly what had caused Sam's death and addressed this with Sam's parents when he met them. The Consultant Paediatrician did not discuss the case with anyone directly involved in Sam's care before speaking to the Coroner's office about the cause of Sam's death.



69. The Consultant Paediatrician had previously told our first investigation that he was informed by a bacteriologist that, even if there had been no delay giving Sam the antibiotics he was prescribed in hospital, it was unlikely that he would have survived. As part of our first investigation we took clinical advice that did not support this view. We subsequently confirmed that Sam's death was avoidable.
70. As part of our second investigation we approached a consultant microbiologist who is an expert on severe streptococcal infections for her view on Sam's case. When the Consultant Microbiologist reviewed our 2014 report she noted the statement attributed to a 'bacteriologist' by the Consultant Paediatrician. She told us that she believed that she was the person referred to as a bacteriologist, and that she recalled speaking with the Consultant Paediatrician on the phone during the Christmas period not long after Sam's death. She told us that the statement made by the Consultant Paediatrician and reported in our first report was not a full reflection of what she had said.
71. Based on the information the Consultant Microbiologist recalled the Consultant Paediatrician provided her with during their conversation, she says she would have said that the child [Sam] might well have not survived if it was at such a late stage of infection. She told us that she offered to review the matter but she was not asked to read the notes or provide written advice. She made no note of their conversation, which she said was unusual and suggested to her that the Consultant Paediatrician was simply '*sounding her out*'. She told us that contracting '*influenza and Strep 'A'*' together is unfortunate but not uncommon especially during an epidemic. The Consultant Paediatrician could not recall his conversation with the Consultant Microbiologist, however, he said that if the Consultant Microbiologist confirmed that it took place he would not disagree with her.
72. Sam's death was reported using the Strategic Executive Information System<sup>9</sup>, within the stipulated 24 hours. This system informs appropriate organisations of incidents it should be aware of and notified the PCT that Sam had died.
73. The Consultant Paediatrician told us that he conducted a debriefing with the paediatric team involved in Sam's care. There is no record of the debrief but he told us that it was primarily concerned with providing emotional support for staff, and did not include other clinicians involved in Sam's care, such as the anaesthetist or the team from the emergency department. The Intensive Trauma Unit Consultant told us that a separate debriefing was conducted with her team to discuss what had happened and if it could have done things differently. This debriefing was also not documented.

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<sup>9</sup> The Strategic Executive Information System (StEIS) is an electronic database set up by the Department of Health for collating weekly management information. All serious incidents requiring investigation (SIRI's) are required to be uploaded. All appropriate NHS organisations monitor StEIS.

74. The Consultant Paediatrician became the Trust's point of contact for the family and met them on the day Sam died to try and explain what had happened. He later met the family again and relayed their concerns about Sam's care to the Trust and the PCT. He also chaired the Child Death Local Case Review Meeting that took place on 4 May 2011, following which a report was completed that concluded Sam's death was expected. He chaired the meeting as the usual chair was unavailable. He told us that he did not think this would be an issue as he saw the purpose of the meeting being to review information from all organisations involved, and to complete the necessary report for the Child Death Overview Panel. The following day he met the family to update them. The family told us that he could not adequately answer their questions.
75. In early January 2011, the Clinical Governance Co-ordinator for child health at the Trust read Sam's medical records and identified that there had been a possible delay in the administration of antibiotics. She told us that statements were collected from staff, although there is little documentation providing any record of her actions. Statements were later obtained from the emergency department nurse, and the two paediatric nurses. There is no record of anyone else being interviewed about the administration of Sam's antibiotics in an attempt to establish exactly what had happened. The Paediatric Registrar was not approached until late May 2011.
76. The Intensive Trauma Unit Consultant attended the Children's Critical Care Case Review meeting in January. This is an internal bimonthly meeting with the paediatricians, the intensive care team, the emergency department team, anaesthetists, nurses, and doctors to discuss the care of children that have needed critical care. She expected to discuss Sam's case but was informed that, as a result of concerns regarding the failure to give the antibiotics in the emergency department, a Serious Adverse Event enquiry had started.
77. In May 2011 a verbal presentation was made to the Serious Adverse Events board by another Consultant Paediatrician and the Intensive Trauma Unit Consultant detailing clinical events in Sam's case. The board was comprised of the executive managers at the Trust, including the Chief Executive and Medical Directors and they also discussed the Trust's own internal root cause analysis report.
78. The Consultant Paediatrician was subsequently invited to attend a meeting on 28 June 2011. The Consultant Paediatrician did not attend this meeting. He told us that he declined to attend as he did not wish to be seen as influencing decisions. The family have said he told them that he did not attend because he had nothing to add and was not due to be working that day.

79. At the meeting that took place in January 2014 with the family, the Trust's Medical Director was asked directly why their concerns had not been answered. He could not give an explanation as to why this matter was not dealt with or any record kept as to how the concerns of the family were being considered. The family told us that at this meeting they were told it would have been better if they had made a complaint.
80. When interviewed as part of this investigation, the then Medical Director said of the Consultant Paediatrician:
- '[He] was an ex-medical director of the Trust, a senior paediatrician. Hugely experienced with no significant issues in the past that suggested that he was anything other than a first rate clinician communicator and so I was putting faith in him. He wasn't someone I was worried about. I didn't have any concerns about [him].'*
- Devon Primary Care Trust**
81. The Patient Safety Manager at Devon Primary Care Trust (the PCT) had a responsibility to co-ordinate the serious incident process. She was informed of Sam's death when it was reported via the Strategic Executive Information System. She told us that she expected the matter to be dealt with by the Child Death Overview Panel via its Rapid Response Team. She told us that, in her view, Sam's death was sudden and unexpected and that a Rapid Response Team would be deployed to ensure all the evidence was obtained.
82. The Patient Safety Manager told us that the Trust informed her that there was to be a meeting between the Trust and the Surgery, arranged by the Patient and Advice Liaison Service (PALS) manager to discuss Sam's case. We have seen no documentary evidence that this meeting took place. However, we have heard evidence that the Consultant Paediatrician spoke to the senior GP at the Surgery.
83. The Patient Safety Manager had received root cause analysis training and had some experience of multi-agency root cause analysis investigations. She notified the organisations involved in the case and requested a timeline from each one. At this point the PCT were unaware that Devon Doctors or NHS Direct had been part of Sam's care pathway.
84. The Patient Safety Manager arranged a planning meeting for 14 March 2011 regarding a root cause analysis. The meeting was delayed until 4 April – we understand because the various organisations had difficulty finding a mutually agreeable date.
85. The Medical Director of the Trust told us he expected the Trust to co-operate fully with the root cause analysis. The Trust told the PCT that the Consultant Paediatrician had held a meeting with staff from the emergency department, the intensive care unit and the relevant paediatricians. However, the Consultant Paediatrician told the Patient Safety Manager that his view was that the root cause analysis was to look only at the community aspects of the care up until the point of Sam's admission to hospital.

86. The Clinical Governance Co-ordinator for child health at the Trust attended the root cause analysis meeting on the 4 April 2011 and reported that the Trust had not completed its investigation. However, she submitted a timeline and a brief report. She was unable to provide any clinical information about Sam's care.
87. The Patient Safety Manager told us that information was being '*drip fed*' to her from the organisations she had approached. She also said that the co-ordinator from the Child Death Overview Panel had said that this was not unusual in their experience. The Patient Safety Manager also told us that the Director of Nursing at the Trust asked her to stop contacting the Consultant Paediatrician on the basis that he was undertaking an investigation.
88. Although the intention was that the PCT review should cover all of Sam's care it told us that, due to a lack of information provided by the Trust, it did not include information regarding what happened to Sam in hospital.
89. The Patient Safety Manager told us that she spoke to Mr Morrish on 13 May and said she was sorry about what had happened to Sam, and apologised for the confusion over the dates of meetings. She told us that when she mentioned this conversation to the Director of Nursing at the Trust she was admonished for making an apology as it implied liability. We asked the Director of Nursing about this but she does not recall the conversation.
90. In May 2011 The Patient Safety Manager prepared and issued a first draft of the root cause analysis report. She said that the Deputy Director of Nursing at the PCT, and her immediate line manager, told her to stop her involvement in the process. However, she was asked intermittently to take action regarding the root cause analysis and describes her subsequent involvement as '*in and out*'.
91. The Director of Nursing for the PCT said that the Patient Safety Manager informed her on a couple of occasions that she was managing a difficult primary care event that was not necessarily a significant incident. She said that she did not perceive it to be a significant investigation based on what she had heard. She said the first time the case was escalated to her was around March 2011. We have seen that both the Director and Deputy Director of Nursing received or were copied into emails from the Patient Safety Manager and others involving the root cause analysis as early as 10 January 2011.
92. The Locality Director for the South Devon and Torbay area of the PCT, raised concerns to the Director of Nursing about how the process was being conducted. He became aware of the concerns via one of his team, who was a PALS employee for Devon PCT and a friend of the Morrish family. She was trying to facilitate the process for the family – though not in a professional capacity.
93. The Deputy Director and the Director have stated that having completed the first draft report it was agreed the Patient Safety Manager should step back on the basis that it was evident she was not coping with the process, and had not escalated the difficulties she was experiencing to her line manager. There continues to be disagreement within the PCT as to whether the Patient Safety Manager appropriately and adequately kept her line managers informed of the progress and problems she was experiencing with this case – with her line managers believing that they were not sufficiently updated.

94. The family said that they felt as though each of the individual organisations were doing their own thing and were not co-ordinating with each other. The Patient Safety Manager had agreed to be the co-ordinator but, at that point, the Director of Nursing thought the PCT were only running the primary care element with the senior GP at the Surgery.
95. The Director of Nursing asked the Deputy Director of Nursing to take over the management of the investigation. She too told us that she did not know much about serious incidents until she became involved in this case. The Deputy Director told us that the Patient Safety Manager had been trying to manage the whole process, had not escalated it when she should have, and had experienced difficulties with the other organisations. The Director of Nursing described some of the organisations as quite obstructive.
96. We asked both the Director and Deputy Director of Nursing why they believed the root cause analysis failed to answer the family's concerns. The Director said that the behaviour of the other organisations made it incredibly difficult for the report to be robust. The Deputy Director described the process as immature and lacking in regulation. She felt there was a general lack of knowledge of the process for investigating serious incidents.
97. The root cause analysis meeting took place on 4 April 2011 and the Patient Safety Manager subsequently prepared a report. However, the report was incomplete because some of the agencies involved did not attend the meeting.
98. The Deputy Director of Nursing explained that once she became involved she spoke with Mr and Mrs Morrish to establish what their expectations were. She agreed to share the report of the root cause analysis with Mr Morrish by 14 May, in accordance with the 'duty of openness', the predecessor to the current 'duty of candour' regulation. She said that although she believed the report was incomplete she provided a copy to Mr Morrish having made the commitment to do so.

### The second PCT review

99. Following the publication of the PCT's root cause analysis it was accepted that the investigation was inadequate and the family were understandably unhappy with the content. Subsequently, The PCT agreed that a further independent investigation should take place and the Chief Executive of another NHS Trust agreed to take this forward, assisted by the Director of Nursing and a Consultant Paediatrician from a neighbouring trust. The family requested that the investigation should be more than a paper based review and this was agreed by the PCT.

100. The Chief Executive met the Morrish family and shared with them his objectives and terms of reference. He confirmed that clinicians would be interviewed as part of the investigation. A completion date was set for 31 August 2011. The day before the report of this second investigation was confirmed, it was shared with the family who said that they felt pressured and unable to fully consider their response in such a short time. The family acknowledged that the second report was an improvement, but felt there were still unanswered questions and that the investigation had not met all of its objectives. The family were offered a third investigation but lacked confidence in the process and approached our office.

101. When we met the Chief Executive who oversaw this second investigation, he said that he believed that the terms of reference would have been sufficient to answer the questions that they had set out because he thought they were broadly agreed. However, he noted that the review was never going to establish why Sam died.

102. He went on to say:

*‘Going back to the why question, from the family’s perspective ‘why’ will be about the clinical aspects of Sam’s care and why there were deficiencies in that care. This is completely understandable. The why question I wish to raise is in relation to our investigation processes in complex cases, when a series of things seems to have gone wrong.*

*Why do we not have coherent and consistent investigation processes? In this Trust we have introduced a ‘Patient Safety Team’. Its role is to investigate*

*serious incidents quickly, consistently and thoroughly, involving family, carers, staff, etc. It is still in its infancy but is based on the notion of an air accident investigation team.*

*In the case of Sam, this was a complex case and arguably a preventable death. It was immediately evident that there had been multiple factors relating to Sam’s illness and ultimate death. In such a serious case, where learning is critical in trying to prevent future deaths of this nature, I believe we should have expert investigation teams that can investigate thoroughly, rapidly, consistently and without prejudice. Not seeking to purchase blame but to understand what went wrong and to determine whether human error, system failure or a combination of the two. A series of clear actions and recommendations should be published and implemented.*

*The current system, certainly in some parts of the NHS, relies on current staff who are not experienced in investigations to carry out what can be very complex investigations. I believe it is critical to ensure we have trained and experienced investigators working to consistently high standards to ensure learning and improvement, to give the public confidence in the thoroughness of investigation and to ensure changes are made as a result.*

*If I was the Ombudsman or the Secretary of State, I would be asking why we do not have rapid, consistent and thorough investigations into cases as complex as Sam’s.’*

## NHS England

103. In August 2013, Sir David Nicholson, the then Chief Executive of NHS England, was informed by letter that we had issued our draft report of our first investigation into the death of Sam Morrish. The matter was passed to the Director of Nursing of the area team for further action. NHS England had not previously been involved in Sam's case. NHS England took the view that there needed to be a collective response to our draft report overseen by NHS England. It wanted the agencies to stop individually deliberating about the minutiae of detail in the draft report, to learn from their mistakes, be open and accountable, and work to implement the recommendations.
104. NHS England identified the need to engage with the family, and for a review of the care of children with sepsis. A steering group was set up to develop the paediatric pathway, Sepsis Assessment & Management (SAM) and the family were invited to be part of this group. The group was also to co-ordinate the responses to the recommendations we made in our first report.
105. NHS England arranged a press conference for the organisations involved to attend so that they could publicly apologise for the failings identified in our report regarding Sam's care and the fact that we had found his death was avoidable. NHS England met the family before the press conference took place to explain the process. The family said that they raised concerns about the press conference. NHS England said that there was no indication that the family were unhappy with the plans and that the family had been invited to attend but declined, and chose to ask an advocate to represent them.
106. The press conference went ahead on the day that we published our 2014 report and statements from each organisation involved were prepared in advance, scrutinised, and rehearsed. The family told us that they were very uncomfortable about this as they felt it was being stage managed. They also questioned how any statements could be prepared with honesty or sincerity when the final report had yet to be issued.
107. NHS England told us that it wanted each organisation to publicly acknowledge its failings and to say it had got it wrong rather than simply apologise. Each of the organisations prepared its own statement, which was then checked for accuracy and to make sure the apology was unreserved. NHS England said the press conference was designed to show they were working together as a health community to prevent such an event from happening again. NHS England chaired the press conference and representatives from the other organisations were present. The family were subsequently given a DVD of the conference. NHS England are adamant that it was not in any way trying to influence what was said by the individual organisations. It said that at all times the organisations had control over what they said about the report.
108. The family were also concerned about the accountability of the Consultant Paediatrician as they knew that he had retired and subsequently removed himself from the medical register. NHS England arranged for the family to meet the Regional Medical Director NHS England to discuss their concerns around the Consultant Paediatrician's medical accountability and de-registration. It is accepted that Consultant Paediatrician left the Trust as part of a planned retirement.

## Our findings

109. Mr and Mrs Morrish complained that in the absence of ‘understanding’ and ‘learning’ about ‘how’ and ‘why’ Sam’s death was deemed unavoidable, investigations and the complaints systems will continue to fail, exposing patients and staff to avoidable risk. In this second investigation we have sought to establish ‘how’ and ‘why’ the organisations involved failed to identify that Sam’s death was avoidable. In doing so, we have paid particular attention to the requirements set out in the *NHS Complaints Regulations 2009*, the *NHS Constitution* and the *Ombudsman’s Principles of Good Complaint Handling*.<sup>10</sup>
110. Mr and Mrs Morrish complained that the NHS investigation review processes are not fit for purpose, believing that they are not sufficiently independent, inquisitive, open or transparent, properly focused on learning, or able to span organisational and hierarchical barriers, and that they exclude patients, their families, and junior staff in the process. In relation to the investigations undertaken after Sam’s death, we agree.
111. We have upheld the complaints put to us by the family about every organisation that investigated aspects of Sam’s care. We have found that those involved were not always suitably independent and that the organisations failed to co-ordinate and co-operate sufficiently with one another. We have identified a failure to obtain appropriate information, a lack of timely statements being taken as part of any formal process and a lack of appropriate (and in some cases any) communication with the family. We have also found a failure to properly include and update the staff at the organisations involved as well as the family.
112. The organisations involved did not work together and undertake one effective investigation, even worse, they failed to undertake their own individual investigations effectively. Opportunities to learn were missed and staff were not adequately supported in their investigatory roles. Had they, at the very least, completed those investigations to a proper standard, it is likely that some answers may have been identified to the questions being asked Mr and Mrs Morrish.
113. The organisations involved made no clear attempt to collectively seek to identify lessons from this case. Without a proper investigation into the events that took place in this case there was no possibility of learning (locally or nationally) or action being taken to avoid such incidents in the future. Had the investigations into Sam’s death been proper at the start, it would not have been necessary for the family to pursue a complaint. Rather, they would, and should, have been provided with clear and honest answers at the outset for the failures in Sam’s care and would have been spared the hugely difficult process that they have gone through in order to obtain the answers they deserved.

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<sup>10</sup> Parliamentary and Health Service Ombudsman (2009) *Principles of Good Complaint Handling*. Available at: <http://www.ombudsman.org.uk/improving-public-service/ombudsmansprinciples/principles-of-good-complaint-handling-full>



114. We think that a fundamental failure in this case was the organisations' – in particular the Trust's – unwillingness to accept that any view other than their own initial view might not be the right one. Those involved appeared to accept almost immediately the view that Sam's death was rare and unfortunate rather than being open to other possibilities and, in doing so, asking open questions as part of a proper investigation that involved staff and the family. This was coupled with a general failure to accept that the questions the family were asking might have been reasonable ones.

115. In particular, we note the PCT's role and the opportunity it had to look holistically at the failures of all organisations involved. We have found that the PCT failed to ensure that the organisations involved in Sam's care were aware of his death and the need to investigate it fully and appropriately. The organisations involved did not work together and undertake one effective investigation. We have found that this was, in part, down to the failure of the PCT to properly and effectively co-ordinate the investigations as required in such circumstances by the NHS complaints regulations.

116. Given this, the failures of the PCT are all the more significant. Had it acted properly, and considered clearly and effectively what the organisations had done compared to what it should have done, it would have identified at least some of the learning that we have identified in this (and our earlier) report. We note that some of the organisations involved were seemingly dependent on the PCT for information about the investigations and communication with the family. Although it is correct to say that the PCT had a key role in co-ordination and communication,

we think it should have been clear to the other organisations involved that this process wasn't working for the family. In the absence of effective co-ordination by the PCT, the organisations involved should have done more to communicate properly and clearly with the family.

117. Most importantly for the family, the organisations involved locally made no clear attempt to collectively seek '*continuous improvement*' and identify lessons from this case. What we have seen has led us to question quite how such a wide ranging investigation involving so many organisations should be undertaken. We believe there is a need for more specific guidance and criteria (nationally) for such investigations in the NHS.

## The Surgery

118. It is clear from the evidence that we have seen that the Surgery was simply not equipped to handle serious concerns such as those raised by Mr and Mrs Morrish. It had no knowledge or experience of investigating serious complaints, the policy that was in place at the time made no mention of serious or complex complaints and how they should be dealt with, and the Surgery had no one trained to investigate complaints. The role of complaint handler should be taken by a member of staff who has been trained appropriately, and they must be provided with the necessary support and guidance to allow them to perform that role effectively.

119. At a meeting at the Surgery, shortly after Sam's death, on 7 January 2011 staff acknowledged they did not know how to conduct an appropriate investigation into the unexpected death of a child because they had no experience of doing so. They correctly sought guidance from the PCT. However, the PCT did not provide adequate support and, rather than proactively chasing the guidance that they had requested, the Surgery floundered.
120. Staff talked to each other about what had happened and reviewed their own practice but did not seek any independent clinical review. They recognised they did not have the skills or experience to investigate such a serious complaint but, having recognised that, they took no steps to ensure they adequately investigated what had happened to Sam at the Surgery. Instead staff wrongly assumed that the Trust was taking the lead because that was where Sam died. They also assumed the Trust was looking after the family's needs.
121. As a result of the Surgery's initial failures, no thorough independent review of the Surgery's treatment of Sam took place at the time. Although, the GPs did discuss the case amongst themselves, they did not identify any problems with the care they provided, for example, they did not identify the significance of Sam's dry nappy. This was a critically important sign of the seriousness of Sam's condition when he was seen at the Surgery. We also note that Mr Morrish raised the issue of the significance of Sam's falling temperature but this went unanswered. Through the course of our investigation we have gathered views from a range of individuals who all agreed that when a child has had a high temperature and the temperature falls, but the child does not appear to be getting better, that this can be a red flag indicator of sepsis when taken into consideration with other symptoms.
122. Staff did not proactively contact Mr and Mrs Morrish after Sam's death and let the Trust communicate with the family. We cannot perceive how the Surgery believed it could have conducted a comprehensive investigation into the care it had given Sam without consulting his family.
123. We recognise that the senior GP subsequently engaged with Mr and Mrs Morrish in a way which they have told us was sympathetic and considerate. However, the Surgery did not take adequate steps to establish the full facts about what had happened nor to seek to establish from the family what their concerns were. This meant the senior GP was unable to provide Mr and Mrs Morrish with direct and full answers to their specific questions. For example, the Surgery told Mr and Mrs Morrish about the PCT's intention to carry out a root cause analysis, but they did not explain this sufficiently so that the family understood what was planned or what would happen.
124. During the Surgery's review, it should have noted that Sam was seen by Devon Doctors. It did not inform Devon Doctors of Sam's death nor did it seek further information from Devon Doctors about the case. When reviewing Sam's care, the Surgery should have contacted Devon Doctors to establish what it had found when treating Sam.

125. Once the Surgery understood that the PCT were investigating it stepped back and relied on the PCT. The PCT let them down badly because its investigation was totally inadequate. We note that the Senior GP went to the PCT's root cause analysis meeting in April 2011<sup>11</sup>, however, he assumed that doctors at the Surgery would be interviewed as part of that investigation and they were not. In fact they were not interviewed until the second PCT investigation in June 2011.
126. The Surgery should have been more proactive in engaging with the PCT's investigation or communicating with the family. The result was that, even after local investigations had been completed, it was not until our first investigation that the facts about what happened to Sam at the Surgery, and the impact of the failures we identified emerged. Furthermore, it is only after this second investigation that we know why the Surgery failed to investigate.
127. No independent review was undertaken by the Surgery and no real efforts made to identify what went wrong. A case such as this required an independent review rather than a peer review. The review should have been completed by someone independent and should have been probing and analytical so that staff could learn from it. Those involved in Sam's care correctly produced statements, but no other documented information was produced. The list of learning points was compiled as a result of the Surgery meeting the family. Although we note that having identified those learning points, and implemented our recommendations, changes have been made.

## NHS Direct

128. We have found several reasons for the flaws we identified in our first investigation on the part of NHS Direct. These were: a lack of a sense of urgency and a failure to act promptly, which led to unnecessary and avoidable delays; inadequate investigation skills leading to a lack of thoroughness; failure to collaborate with other agencies; and poor communication with the family.
129. Having been informed of Sam's death in March 2011, NHS Direct correctly identified that the process followed during this incident required scrutiny, and commissioned a review of the process for managing adverse incidents within NHS Direct. This review found that there were unreasonable delays in NHS Direct's responses to the root cause analysis that was being undertaken by the PCT.
130. In March 2011 the Patient Safety Manager at the PCT emailed the Regional Clinical Governance Lead at NHS Direct three times regarding the root cause analysis they were undertaking, requesting information and alerting her to NHS Direct's involvement in the investigation. The emails were not opened for three weeks because the Regional Clinical Governance Lead was on leave and, although an automatic reply had been placed on the account, there were no contact details for re-direction and no one was checking the email account in her absence. We consider the lack of appropriate cover in this instance was unacceptable.

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<sup>11</sup> The Senior GP was the only person present at the meeting who was medically qualified.

131. Once aware of the investigation, the Regional Clinical Governance Lead's response was initially prompt. A suitably senior and independent person (the London Regional Clinical Governance Lead) reviewed the computer record of Mrs Morrish's telephone call with NHS Direct regarding Sam on the evening of 22 December and passed a preliminary view to the PCT. NHS Direct identified that a 'higher disposition' would have been appropriate but that it did not consider that the call was 'unsafe'.
132. NHS Direct submitted a timeline for the PCT's root cause analysis meeting on 4 April but it did not supply a detailed report. We note that the reason given for not being able to supply the report was the time frame within which it was requested. However, we question whether, had the Regional Clinical Governance Lead arranged for her email account to be monitored in her absence, it would in fact have been possible for NHS Direct to complete the investigation in the timescales required. Furthermore, we note that NHS Direct chose not to send a representative to the PCT multi-agency root cause analysis meeting. We consider that it should have attended that meeting as well as the Child Death Review meeting in May 2011.
133. We have also identified that the Incident for National Review notification was not submitted until 13 days after the Regional Clinical Governance Lead was informed of the incident by the PCT. NHS Direct policy stated that it should have been submitted within 24 hours. This delay was unnecessary and could have been avoided. We have seen that NHS Direct suggested that the gap between Sam's death and NHS Direct being informed, was a contributory factor in the delay in raising the Incident for National Review notification. However, we do not agree that this is an acceptable reason for the time taken.
134. Furthermore, once instigated, the local management review of Mrs Morrish's call to NHS Direct was delayed by a month because a range of staff within NHS Direct did not provide information on time despite being urged to respond. Information was initially requested on 14 April with a completion date of 28 April. Self-reviews from the Health Advisor and the Nursing Advisor were also requested to be completed by the same date – 28 April. However, the responses were not received in full until 26 May. The review was not signed off until 28 May and did not reach the National Clinical Governance team until 31 May. This was eight weeks after it was requested, and well outside NHS Direct's policy guidelines of 28 days.

135. We also note that NHS Direct did not identify the discrepancies between the computer record and the recording of the call with Mrs Morrish. In our first report we outlined that it was clear from the records that the Nurse Advisor had answered questions in her report that she had not actually asked Mrs Morrish. These discrepancies were not picked up by NHS Direct. Internally, no major failures were picked up in the reviews – the practice development coach and the clinical development lead both felt there were no issues, grading the call as ‘good’, and no action plan was instigated.
136. We do not know how the discrepancies were not identified by NHS Direct. However, we do consider that it is inconceivable for them to go unnoticed had the call reviewers carefully and properly reviewed both sets of records of the call. On that basis we must conclude that the reviews of the call were not conducted thoroughly, and as such were flawed. It is unacceptable that Mr Morrish had to point out these discrepancies to NHS Direct.
137. Had the reviews been conducted correctly, NHS Direct would have been in a position to inform Mr Morrish what had happened, and would not have had to react to his concerns. More worryingly, as a result of this failure, there was a delay in recognising the significant patient safety concerns about the Nurse Advisor who continued to work unsupervised. NHS Direct later accepted that the subsequent lack of supervision of the Nurse Advisor and the delay in initiating an action plan were of significant clinical concern. There is nothing in the evidence that we have seen to indicate if any action was taken with regard to the failures in the management reviews that were conducted into this case. However, we note that it was not until our first report was published that those failings truly came to light by which point NHS Direct had been disbanded. On that basis, the action that could have been taken with regards to the management input into the reviews was limited.
138. NHS Direct wrote to Mr and Mrs Morrish on 9 June 2011 with the outcome of the National Peer Review Meeting. As the meeting should have taken place within 40 working days this was a week overdue. Furthermore, the letter was written and sent before the review report had been agreed by panel members or senior managers. This meant proper input from those involved was lacking from the response that was sent to the family, which perhaps unsurprisingly, they found to be brief, superficial and underplayed the significance of what went wrong. This caused further upset to the family. The final report was not approved and signed off until 29 November. It was published in December 2011 – one year after Sam’s death. The NHS Direct Adverse Incident Management policy in place at the time stated that such documents should be circulated within ten days of the review. We have not seen any evidence to explain the delays and on that basis we consider the time taken to be unacceptable.
139. Finally, NHS Direct compounded its errors by beginning its review without talking to Mr and Mrs Morrish. Because of this, and the fact that the staff at NHS Direct chose not to attend the PCT’s root cause analysis meeting, NHS Direct was not adequately informed to fully investigate its involvement in Sam’s death.

140. It is clear to us that NHS Direct did not recognise the significance of this investigation and the level of importance it warranted. Its own existing time frames were ignored consistently, which resulted in unacceptable delays and the investigation that was conducted failed to identify the errors we later pointed out in our first investigation report. Furthermore, NHS Direct failed to attend the meeting it was invited to by the PCT and, in common with other organisations involved in Sam's care, the communication with the family was poor.

### Devon Doctors

141. Our investigation has identified that Devon Doctors was inexperienced and not equipped to deal with such a serious complaint. It did not engage effectively with the multi-agency investigations that were led by the PCT and it failed to communicate appropriately with Mr and Mrs Morrish.
142. Having become aware of Sam's death Devon Doctors reviewed its records but could not establish precisely what had happened and decided not to contact the on call doctor immediately to ask him. We note that it has said that it required the audit trail of the call before questions could be asked. However, because of a delay in accessing the information Devon Doctors missed an early opportunity to get the on call doctor's account while it was still fresh in his mind. As a result, Devon Doctors failed to recognise its role in the failures in Sam's care and treatment early on.
143. Devon Doctors did nothing further until some months later after, by chance, it heard that the PCT was investigating the circumstance of Sam's death. Although it co-operated with the PCT, it did not

recognise that it should do more itself, for example, contact Mr and Mrs Morrish. Just like the Surgery, Devon Doctors assumed the PCT was doing everything, in particular engaging with Mr and Mrs Morrish. Had it talked directly to Mr and Mrs Morrish as early as possible, additional distress for the family could have been avoided.

144. Similarly, Devon Doctors passed its responses to Mr and Mrs Morrish's questions about what happened to the PCT. We consider that direct contact with the family could have avoided the subsequent confusion and misunderstanding about those questions and responses.
145. We note that a report prepared by Devon Doctors setting out its investigation into what happened, has only ever been shared in draft with Mr and Mrs Morrish. Again it seems Devon Doctors wrongly assumed the PCT would engage appropriately with the family and provide them with answers to their questions about the role of the out-of-hours service in Sam's care and treatment. The result was that, even after local investigations had been completed, it was not until our previous investigation that the facts about the role of Devon Doctors in what happened to Sam, and the impact of that involvement, emerged.
146. Devon Doctors did not have much experience of being involved in a multi-agency root cause analysis enquiry. It was asked to produce a timeline, but otherwise given no direction. Devon Doctors believed that the information it gave to the PCT's root cause analysis was being relayed to the family and expected information from the family to be fed back to it. It should be noted that Devon Doctors have subsequently addressed all of the issues raised by this case.

## The Trust

### *The care and treatment provided to Sam – the delay in administering the antibiotics*

147. This section of the report is the only area where we have looked again at specific aspects of the care and treatment that was provided to Sam in the days immediately prior to his death. In particular, as part of this second investigation, we have looked further into the reasons why there was such a delay in administering the antibiotics that were prescribed for Sam almost immediately on his arrival at the Trust.
148. We know that the Consultant Paediatrician made a clinical assessment and decided to transfer Sam to the high dependency unit. We note that there was a discussion about this decision. As we found in our first investigation report, although the decision to transfer Sam was appropriate based on the information the Trust had obtained, we did not believe that the Trust had taken the necessary advice to appropriately inform that decision<sup>12</sup>. Regardless of whether the decision to transfer Sam was taken appropriately or not, the family said they were included in this discussion and felt they were part of the decision-making process. They considered this was unhelpful and wholly inappropriate as they were in distress and not able, or qualified, to make this kind of judgment. Although the family were rightly informed of why Sam was taken to the high dependency unit as opposed to the intensive care unit, they should not have been involved (or at the very latest made to feel involved) in the decision making process. The decision taken was one solely for the clinicians to make.
149. One of the most important unanswered questions from our first investigation report was ‘why’. Why was there a delay in administering the life-saving antibiotics to Sam that were prescribed in the emergency department? Although we correctly identified what should have happened compared to what did, as was our process at the time, we did not go one step further in order to establish why the errors were made. We have now done this given the wider lessons that we believe can be taken forward from this case across the NHS.
150. We have found that doctors did not act in line with *Good Medical Practice* and nurses did not act in line with *The Code*<sup>13</sup>. It is apparent to our investigation that this delay was caused by poor decision making about priority actions and a breakdown in communication between staff caring for Sam.

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<sup>12</sup> In our first investigation report we found that doctors should have sought advice on how best to treat and manage Sam's condition with the Paediatric Intensive Care Unit in Bristol.

<sup>13</sup> *Good Medical Practice 2006* set out the duties of a doctor registered with the General Medical Council. Amongst other things it says how doctors must work effectively in teams and that sharing information with other healthcare professionals is important for safe and effective patient care. *The Code: Standards of conduct, performance and ethics for nurses and midwives 2008* sets out how the Nursing and Midwifery Council expected nurses to act and behave. It describes the importance of working effectively as part of a team and sharing information with colleagues.

151. The Paediatric Registrar, who prescribed the antibiotics, said that he told a nurse to administer them. However, the nurse looking after Sam in the emergency department said she was not told about antibiotics, and when she became aware of the delay, she was told they were to be given on the ward. She said she informed the paediatric ward of this. The paediatric nurses do not recall being told this.
152. Once the antibiotics had been prescribed, the administration of those drugs should have been immediate. Furthermore, as soon as it was realised that the antibiotics had not been given, they should have been. Instead the decision was made to delay their administration until Sam had been transferred to the high dependency unit. Not only was this decision flawed, there was clearly a breakdown in communication that led to further unnecessary and avoidable delay.
153. We note that the Consultant Paediatrician returned home once he was satisfied with the treatment plan put in place for Sam, remaining in contact by telephone. This is standard practice and reflected the fact that he did not consider Sam's condition to be life threatening.

#### *What happened after Sam died and why*

154. The Consultant Paediatrician informed the Coroner's Office about Sam's death during the morning of 23 December and provided a cause of death. However, he did not know at that point that there had been a delay in giving antibiotics because he had not studied Sam's records adequately. This meant that he did not give the Coroner all of the information and so the Coroner's decision not to hold an inquest was not based on a complete picture of what happened to Sam. We cannot say whether the Coroner would have held an inquest had they been aware of all of the facts. However, we do consider that the Consultant Paediatrician's actions led to another missed opportunity to find out as early as possible how and why Sam died.
155. We have also found that there was no documented cross-departmental debriefing undertaken at the Trust to identify poor, or indeed good, practice, and learning for the future. There is also no evidence that the results of each individual debriefing that we have been told took place were compared or cross referenced with each other.
156. Turning to the communication with the family, we do not consider that it was inappropriate for the Consultant Paediatrician to meet the family to deliver his clinical opinion and medical explanation as to why he thought Sam had died. However, what we do not believe was appropriate, or indeed fair on either party, was for the Consultant Paediatrician to act as the point of contact for the family on behalf of the Trust. In doing so, he met the family and relayed their concerns to the PCT, however, there was little or no co-ordinated communication with Mr and Mrs Morrish. This was not an effective process and meant that when he met Mr and Mrs Morrish the Consultant Paediatrician was not able to explain the scope and purpose of the reviews being conducted.
157. We note that the Medical Director told us he had no concerns about the Consultant Paediatrician's communication skills and, as such, did not check what he was doing. Furthermore, the Trust has also stated that the Medical Director had no reason to believe that anything was wrong at that point in time from the family's perspective with communication.



158. We cannot say that the Consultant Paediatrician was appropriately supervised in his role. Rather, an assumption appears to have been made that he was an experienced and respected member of staff and as such there was no need to check on his actions. Furthermore, in taking this approach, we consider the Trust was not sensitive to the family's needs, nor do we think it was fair for the Trust to place the Consultant Paediatrician in this position as he should not have been asked to have such contact with the family given his involvement in Sam's care.
159. A single point of contact must be central to any investigation particularly if the investigation is complex and into an unexpected death. This did not happen in this case and resulted in the family receiving mixed messages and having to be persistent in order to get answers to their questions. As a result of continued poor communication and an apparent failure to listen to Mr and Mrs Morrish, they developed the impression that they were being ignored or 'managed'. For example, they were sent some replies to emails that were abrupt and insensitive – they were also referred to in our first investigation. The family felt their voice was not being heard by the Trust. Under the circumstances it is unsurprising that communication broke down between the Trust and the family. We consider that, in cases such as this, if a point of contact is appointed that person should have the necessary time and skills to devote to the role.
160. Turning to the Consultant Paediatrician's involvement in the Child Death Review Panel, the family said that it was inappropriate for him to have chaired the local case review and we agree. We consider that his decision to chair the Review Panel called into question the independence of that process by creating a potential conflict of interest and lack of objectivity, openness and accountability, all of which are essential in this process. The Trust was aware two weeks before the meeting that the usual chair was not available and had, in our view, sufficient time to identify another paediatrician, independent of the care of Sam, to chair the meeting.
161. Regarding the Trust's investigation into the concerns raised by the family it is clear that, had a thorough investigation taken place, a clearer picture would have been established particularly with regard to the delay in providing Sam with the necessary antibiotics. The Trust did not conduct a proper investigation and as such was not able to inform the family why there was a delay in administering the antibiotics. A clinical debriefing should have been conducted with all staff involved in Sam's care. Staff should have been interviewed as part of a serious investigation and statements or verbal accounts recorded while events were still fresh in their minds to establish exactly what had happened.

162. We note that the Trust had a policy for the investigation of Serious Untoward Incidents and that document details the circumstances when a full investigation should be started, providing clear and detailed instructions as to the conduct of that investigation. It is clear that policy was not followed despite the fact that, from what we have seen, the Trust told the PCT that it was conducting an inquiry. We consider the Trust should have completed an investigation in line with its policy at the time and submitted the findings to the PCT's root cause analysis. Had the Trust followed its own policy it seems likely that the Trust would have established at least some of the answers to the questions the family kept asking as to what had happened and why Sam had died.

163. Furthermore, the Clinical Governance Co-ordinator for child health at the Trust told us she had no experience of a governance role and had requested further training from the Trust. She told us she felt the training she had received was insufficient, and left her lacking in confidence in her ability to complete the role she played in obtaining evidence and statements in relation to Sam's death.

164. The Trust has told us that it thinks it would have handled the concerns raised by Mr and Mrs Morrish in a better way had they been put forward as a formal complaint. Irrespective of whether or not a complaint was made, the Trust had an obligation to thoroughly investigate this case under the guidelines set out by its own procedures and the *NHS Complaint Regulations*. Furthermore, we find it extraordinary that nobody recognised that the concerns of the family, while not intended to be a formal complaint,

essentially amounted to the same thing and were deserving of answers. Moreover, we agree with the family that it should not be necessary for a formal complaint to be made in order for a family in their position to find out what happened to a loved one and why.

## The PCT

### *The first investigation by the PCT – the Root Cause Analysis*

165. The PCT's root cause analysis investigation did not make sufficient efforts to establish what organisations were involved in Sam's care. Nor did the investigation establish early contact with the family. The PCT should have approached the family at the beginning to listen to their story allowing the family's account of events to be central to any investigation or root cause analysis. Instead, the family were not asked for their account of events and felt excluded from the processes. They subsequently supplied their own narrative, which was adopted by the root cause analysis. The PCT's lack of communication led the family to believe that the other organisations did not care. This should not have happened.

166. We note that the PCT was not helped by the fact that other organisations involved did not pass on relevant information, for example, the Surgery had been informed of Devon Doctors involvement but did not pass this information to the PCT. Furthermore, the Patient Safety Manager was trying to complete a root cause analysis for the whole of Sam's care pathway and a lack of information from NHS Direct and the Trust reduced the effectiveness of that.

167. Overall, the PCT's role was potentially the most important when considering what happened to Sam and why. It had the opportunity to holistically review the care provided by all organisations and identify learning. Ultimately, we consider that the PCT was never going to get to the bottom of what happened because it appeared to accept wholeheartedly that Sam had a rare condition. It seems to us that this was almost certainly a result of the information received from clinicians and, in all probability from the Consultant Paediatrician, who appears to have equally unreliably based this conclusion on a brief conversation with an expert who did not have all of the information available to her when commenting.

168. More could, and should, have been done to establish the facts of Sam's death and the reasons for the failures that occurred in the care provided. Sepsis is not rare and more should have been done to investigate independently all aspects of the case. This was an unexpected death of a child and should have been treated as a serious incident and properly investigated as such – it was not. Furthermore, the family's questions, while not strictly complaints, were clearly concerns that required or expected a response. This should have prompted action in line with the *NHS Complaints Regulations* and our *Principles of Good Complaint Handling*.

169. Investigations must be conducted by appropriately trained staff who are provided with the right level of support and who are recognised externally as having the authority to undertake the work. The lead for the investigation was trained in root cause analysis but in cases such as this we consider there is

also a need for trained investigators to be involved. It is clear that, in this case, the Patient Safety Manager was not sufficiently experienced and was not considered to have the authority to carry out the investigation. We believe that she should have recognised that and asked for further support. Equally, we consider that her managers should have recognised the need for that support and arranged it.

170. The result of the failures of the PCT, together with a lack of engagement by the other organisations involved, was a flawed and incomplete report. The fact that the PCT issued such a report exacerbated the feelings of mistrust held by the family and further contributed to a breakdown in the relationship with them.

#### *The PCT's second investigation*

171. The second investigation was led by the Chief Executive from a mental health partnership trust with support from two senior clinical staff from a neighbouring acute trust. His goal was to be inclusive, open and transparent and he achieved some of the aims and objectives in the terms of reference for the investigation. However, the Chief Executive recognised that his investigation was inadequate. Rather, it was planned as another paper-based review. Although interviews with clinical staff were carried out, these were undertaken at Mr Morrish's insistence. Overall, we consider that the Chief Executive underestimated the level of detail and depth of understanding of what was required in order to establish what happened to Sam. He did not have the capability or mandate to organise such a review.

172. We note that the second investigation achieved some, but not all, of the objectives and aims within its terms of reference. The investigation failed to fully review the earlier investigations carried out by the various organisations. Had it done so, it would have established that it was Mr Morrish who discovered the errors made by the Nursing Advisor and not NHS Direct. Once again, Mr and Mrs Morrish were left with unanswered questions and no further thought was given to how their expectations could be met. The PCT offered no help in resolving their unanswered questions and the family were left to take up the outstanding issues with the individual organisations.
173. Furthermore, although the report was shared with the family, this took place the day before it was due to be signed off. The family said that they felt pressured and unable to fully consider their response. They had not been helped to prepare for that meeting where details of Sam's condition were explained to them for the first time only eight months after Sam's death. This was insensitive and meant the family could not contribute as much as they wanted to the final report. The family should have been given time to digest the information. It would have been better to have had some flexibility regarding the deadline for completion and publication of the report, possibly allowing for a further meeting so that the report could be discussed again with the family once they had been given a chance to consider the report properly.
174. Looking back at both of the investigations undertaken and commissioned by the PCT it is clear to us that neither were properly thought through nor did they truly have the needs of the family in mind. The initial investigation lacked thoroughness, information received from the organisations was accepted without question as to its completeness or accuracy and there was a lack of co-ordinated internal communication.
175. In both cases it was not clear that all those involved – including the family and the staff – fully understood what the investigation would look like. This was due to a lack of effective communication with the family, which left them dissatisfied when the review was completed with questions left unanswered. In cases such as these, once it is agreed that an investigation is required then it must be an investigation and not merely a review.

### NHS England

176. We did not consider NHS England's actions as part of our previous investigation. At the outset of this investigation Mr and Mrs Morrish asked us to look into this organisation. They complained that they had been 'managed' by NHS England. They had not found NHS England to be open and accountable and they said the actions of NHS England further exacerbated their distress. They also noted that a large part of the press conference was spent explaining what had been done to raise awareness of sepsis in the wider community, including a *Sepsis Assessment and Management* leaflet specifically aimed at helping the public identify signs of sepsis in children.

177. Although NHS England took action when notified of the case by our report, the way in which it acted further caused distress and concern for the family. NHS England recognised that there was no one organisation responding to the recommendations of our previous investigation and organised a collective response, which was overseen by it. It wanted the organisations to stop focusing on the detail of our draft report, to learn from its mistakes, to be open and accountable and to work to implement our recommendations. It organised a meeting with us and the leads from all the organisations involved in Sam's care.
178. NHS England realised that Mr and Mrs Morrish had never met senior staff at the Trust other than the Consultant Paediatrician. Mr and Mrs Morrish expressed concerns about the Consultant Paediatrician's accountability. The Director of Nursing arranged for Mr and Mrs Morrish to meet the Regional Medical Director for NHS England to discuss their concerns.
179. NHS England decided to arrange a press conference for all the organisations involved in Sam's care to coincide with the release of our final report. This was partly to allow for those organisations involved to apologise publicly for their failures. Statements from each organisation were prepared in advance, scrutinised and rehearsed. Mr and Mrs Morrish say they were uncomfortable with this approach as it appeared to them that the press conference was 'stage managed'.
180. Mr and Mrs Morrish say that they made clear to NHS England at the time that they were uncomfortable with the way in which the press conference was being handled. NHS England, however, say that no such concerns were raised and that they met the family the day before the press conference to explain what would be happening.
181. NHS England stated it was necessary to check the accuracy of the statements being made and to ensure that the organisations were going to acknowledge all of their failings and not simply offer weak apologies. It said that the aim was to show that they were working together as a 'health community' to prevent or reduce the potential for what happened to Sam to happen again.
182. There is no evidence that NHS England inappropriately influenced what was said at the press conference. Furthermore we accept that there was a need to ensure before the press conference took place that the statements being made were accurate and sincere. Unfortunately, the answers provided by staff to some of the direct questions that were asked at the press conference about lack of openness and why it had taken so long to get answers to the family's questions were such that Mr and Mrs Morrish felt as though the press conference was purely about providing public reassurance rather than answering their concerns.

183. We can see that NHS England went to great efforts to ensure that the family were kept informed about the press conference and how that would be taken forward. We also understand the need for such planning and preparation under the circumstances. Ultimately we consider that the family were not likely to be reassured by anything that NHS England said or did at the press conference. In the absence of an adequate investigation the family were always likely to have questions that the organisations were unable to answer. This highlights the importance of getting it right at the outset and approaching the investigation of such a serious incident with an open mind recognising the need to be open to other possibilities in a serious incident such as this. Furthermore, it seems to us to be inevitable that the family found the apologies and statements provided at the press conference to be insincere given the staged nature of such an event – something we cannot see could have been avoided by NHS England. However, had the family known that the organisations involved had gathered all of the information necessary in order to learn from the mistakes that had caused Sam's death, the statements and apologies provided may have had more meaning.

## Injustice

184. We have upheld the complaints put to us about every organisation that investigated the complaints raised by the family in relation to Sam's death. We have found failures in each organisation's handling and communication and we have noted that those failures meant that the family had to wait far too long for answers regarding what happened to Sam and why. The time taken to obtain those answers and manner in which the organisations involved

communicated with the family added significant distress and upset to that which had already been experienced as a result of Sam's death. This is a significant injustice.

185. We have found that the organisations involved in this complaint did not work together and undertake one effective investigation. Moreover, they failed to undertake their own individual investigations effectively – opportunities to learn were missed – and the organisations involved made no clear attempt to collectively seek to identify lessons from this case. Without a proper investigation into the events that took place in this case there was no possibility of learning (locally or nationally) or action being taken to avoid such incidents in the future.
186. Had the investigations into Sam's death been proper at the start, it would not have been necessary for the family to pursue a complaint. Rather, they would, and should, have been provided with clear and honest answers at the outset for the failures in Sam's care and would have been spared the hugely difficult process that they have gone through in order to obtain the answers they deserved.
187. As we have noted, a fundamental failure in this case was the organisations' unwillingness to accept any view other than their own. Those involved appeared to accept almost immediately the view that Sam's death was rare and unfortunate rather than being open to other possibilities and, in doing so, asking open questions as part of a proper investigation that involved staff and the family. Without a willingness to consider other possibilities investigations such as those undertaken into Sam's death are destined to fail.

188. To be truly accountable we think that willingness to accept other possibilities is one of three requirements outlined in the summary of this report. Without being open, and in doing so, completing a proper investigation involving both staff and the family, it is not possible to identify the necessary learning and take appropriate action to put matters right. Mr and Mrs Morrish had hoped for a proper investigation, the results of which would answer their questions about their son's death and provide them with a better understanding of what happened and why. Instead they were left with a continued lack of confidence in the local organisations.

## Our recommendations

189. We have separated our recommendations into two areas: recommendations to remedy the injustice to the family that we have identified in this report and wider system recommendations to be taken forward by the NHS.

### The family

190. We would usually recommend that the organisations apologise to the family for the errors identified in this report and the injustice caused as a result. However, the Morrish family have said that they do not wish to receive any further apologies or financial compensation in relation to their complaints.

### The organisations involved in this complaint

191. We recommend that the organisations consider and reflect on this report, on what steps they have taken since our

first investigation report to improve their service, and on what further work can be done to continue to improve their service and patient safety.

192. We recommend that the organisations involved provide details of the action they are taking to NHS England within three months of the date of this report so that NHS England can consider the best way to involve and update the family on the steps being taken.

### The system

193. We recognise that the failings we have identified in this case are not isolated. Across the NHS a fear of blame pervades that prevents individuals and organisations being open to the possibility that their initial view of what happened might not be the right one, and means they are not asking questions about what happened and why. As a result, investigations into cases where potentially avoidable harm occurred are not being routinely carried out and learning therefore cannot be shared to prevent harm occurring again. For the NHS to learn from cases such as the Morrish's, and improve patient safety, they must address these issues.

### Competence

We concur with the five areas for improvement identified by the recent CQC Briefing: Learning from serious incidents in NHS acute hospitals<sup>15</sup> :

1. Serious incidents that require full investigation should be prioritised and alternative methods for managing and learning from other types of incident should be developed.

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<sup>15</sup> Care Quality Commission (2016) *BRIEFING: Learning from serious incidents in NHS acute hospitals. A review of the quality of investigation reports*. June 2016. Available at: [http://www.cqc.org.uk/sites/default/files/20160608\\_learning\\_from\\_harm\\_briefing\\_paper.pdf](http://www.cqc.org.uk/sites/default/files/20160608_learning_from_harm_briefing_paper.pdf)

2. Patients and families should be routinely involved in investigations.
3. Staff involved in the incident and investigation process should be engaged and supported.
4. Using skilled analysis to move the focus of investigation from the acts or omissions of staff, to identifying the underlying causes of the incident.
5. Using human factors principles to develop solutions that reduce the risk of the same incidents happening again.

There are also improvements to be made in communication, co-ordination and governance within and across organisations.

As we noted in our report into *the quality of NHS complaints investigations where serious or avoidable harm has been alleged* we recommend training and accrediting sufficient investigators to operate locally. We also believe there is a need for the role of NHS complaints managers and investigators to be better recognised, valued and supported.

We welcome the role that Healthcare Safety Investigation Branch (HSIB) will play in developing and promoting best practice to take this agenda forward.

## **Culture**

The impact of actions to improve competence will be limited without a parallel focus locally and nationally on creating a just culture. Tackling the current defensive culture and fear of blame requires soul searching and bravery at every level from politicians to system leaders, organisational leaders, clinical leaders and front line staff.

The focus on a 'safe space' for the investigations of the new HSIB is absolutely a step in the right direction. However, all but a very small number of investigations will continue to be conducted locally, just like this one. Now is the time for the NHS to build on the momentum started by the creation of HSIB and explore how it can give staff across the NHS the confidence to be open to exploring what happened so that, if mistakes were made, they can learn and improve safety for others in future.

We recommend that NHS system leaders (including NHSi, NHSE, Department of Health and CQC) consider how they can provide collective and collaborative leadership to create a positive, no blame culture in which leaders and staff in every NHS organisation feel confident to openly investigate and report, learn and improve patient safety.



## Chapter 4: What we have learned from the Morrish family's complaints

194. Following the publication of our first report and our decision to undertake a second investigation, we agreed to look at how we handled Mr and Mrs Morrish's first complaint so that we could learn from their experience and consider how that learning might inform our work in future. We are part way through a very significant modernisation of our service and so we have been able to build the learning from the family's feedback into that process. As such, the family's experience has fed into both our service improvements and how we have developed our role in order to maximise the insight from complaints and feed the learning back to service providers for improvement.

### Our role

195. We recognise that when we received their first complaint about Sam's care we played a limited role in developing and using the insight from our casework to help others improve public services. Developing insight from complaints has been a key part of our strategy since 2013 and our approach has developed considerably since Mr and Mrs Morrish first came to us. We want to continue to use our insight to help increase the capabilities of those who handle complaints in public services and to support Parliament in holding public services to account.

196. We now work to generate insight into poor complaint handling and learning from complaints, to help others develop solutions. This report is part of that activity and is one of three ways in which we are taking this work forward.

### *Thematic reports*

We have increased the number of reports published on big and repeated mistakes. In doing so we have been able to show what other organisations in the wider NHS can learn from our findings in areas such as Midwifery Regulation, Sepsis, and the quality of local NHS complaint investigations about potential avoidable harm or death. These reports have supported the Public Administration and Constitutional Affairs Committee in their scrutiny of government learning from complaints. Our work on the quality of local investigations contributed to the committee's recommendations on both the establishment of the new Healthcare Safety Investigation Branch (HSIB) and on improving local competence to investigate incidents such as the death of Sam Morrish.

### *Individual cases*

We have changed the way that we investigate the small number of cases each year where we think we may find evidence that can contribute to wider learning across the NHS. Those investigations are now being undertaken by a small team with specific family liaison points and an assumption that interviews are completed. This second investigation for the Morrish family is one of those cases and the insight for the NHS as a whole is brought together in chapter 1 of this report.

### *Recommendations to put things right*

If we see flaws in an organisation's investigation we will make recommendations for remedy that include the local NHS organisations revisiting the case to conduct a more thorough investigation. This would include using investigation methods that enable them to establish both what happened and why so that the findings can be used to learn and improve patient safety.

197. We recognise the mismatch between people's understanding and expectation of our role and the reality. Last year we began work to articulate and communicate our role more clearly to the public in all our communications, including when we are looking into a case.

### **Our service**

198. We have seen how, in Mr and Mrs Morrish's case, our own methods of investigating and our interactions with the family mirrored some of what they experienced locally. Senior members of our team met with Sue and Scott Morrish after our first investigation, and apologised that we had not got it right for them in some aspects of our service. We have worked with them to understand their concerns in detail so that we can continue to learn and improve our service.
199. The feedback the family gave us about our first investigation fit broadly into three areas. They were unhappy about the scope of our investigation and the method we used to conduct it, they said they were unhappy that we did not keep them informed, and they had concerns about the service in general that we provided, for example, the time taken to complete our investigation.

### *Scope and method*

200. The family said we did not listen carefully enough to what they wanted as an outcome from their first complaint: we focused on determining if there was service failure and whether or not their son's death had been avoidable. When we complete an investigation we consider what happened and what should have happened, and whether the gap in between the two is great enough for us to find fault with the organisation's actions. If we find that it is, then we uphold the complaint. However, they hoped our investigation could find out why the local services failed to conclude that Sam's death was avoidable, and what they could learn from this in the future, particularly for NHS incident investigations. This second investigation used a different method (including interviews) so to increase understanding of how and why things happened not just what happened.
201. The family said our method was not transparent and this meant they could not check if it was going to deliver what they actually wanted from the investigation. They also said that our methodology was not adequate for achieving answers to all of the questions they had. In the end there was a mismatch between our method to establish what happened and their desire for local and system wide understanding of why Sam died and why the local organisations failed to identify their failures, in order to learn and improve patient safety. We need to do more to clearly explain the methods we use.

202. The family also had concerns that, during our first investigation, documents we sent them contained factual inaccuracies and speculation. In complex cases in particular, we can do more to share and check the facts with all parties involved at an earlier stage in the investigation process. We need to separate clearly in our reports the facts of the individual cases from our findings. We also need to be clear with the parties that one of the key reasons we share our reports in draft with the parties involved is to ensure the accuracy of the facts.

### *Providing a good service*

203. The family told us they felt they had to continuously contact us to find out what was happening with their complaint. They also said that it felt as though we were ‘managing’ their contact with us, and that we seemed to view their contact as a hindrance rather than a help.

204. We must be clear about when and how we will contact the parties involved.

205. One of the family’s key concerns was the time we took to complete our investigation – from April 2012 when we first received the complaint, to June 2014 when we finalised our report.

206. We must be clear that the staff conducting the first investigation followed our methods and service standards at the time. It was our corporate standards that needed to change.

## Accountability

207. Importantly for the purpose of this report we have tried to follow the three key elements of NHS accountability outlined in chapter 1 of this report in describing what we have done to improve our service:

- i. Being willing to accept your own initial view might not be right and to ask open questions as an individual and as an organisation about what happened. In other words to do a proper investigation that involves all staff who provided diagnosis, care and treatment and the patient or their family. Providing staff and patients and families with a full explanation of what happened and why
- ii. Learning from the investigation and taking steps to improve the service
- iii. In the longer term providing evidence of performance against that expected as a result of the improvements being made – being able to assure the service leaders and the public that the service has improved

### *i. Listening to, and understanding, feedback*

208. The family’s criticism of us when we completed our first investigation into their case was one of the triggers to change our own processes. We have listened to the feedback from them, and others, who have brought their complaints to us for a final decision as well as listening to the views of staff in the organisations we investigate. As a result we have developed new quality standards with people who use our service which will be launched in July 2016.

209. It will take us time to fully meet those standards. We also know from the experience of ombudsman services (across the UK and internationally) that complainants' acceptance of our service and decisions are linked to whether they view the outcome of the investigation favourably. However, we like any organisation, we will sometimes make mistakes and have processes in place to listen to feedback and concerns and take action to put matters right if we have made an error.

210. The four things that people say give them most confidence in our decisions and service are:

- to understand our role, what we can and cannot do and to be kept informed;
- a robust, impartial and transparent process of looking into their complaint starting with listening to what people think the service failure is, and the outcome they are seeking by bringing their complaint to us;
- to receive a service which is accessible, treats people with respect, is completed as quickly as possible and looks after their personal and confidential information; and
- to be able to see how we are doing against these expectations

*ii. Learning and action to improve our service*

211. We have used what we have learnt from this case to feed into our greater understanding of what people want and expect from our service. Our new quality standards include new expectations for:
- a. communicating with complainants and organisations we investigate;
  - b. the way we listen to complainants and feedback the scope we intend to investigate;
  - c. how we provide an investigation plan for each case and explain how long that case is expected to take;
  - d. conducting interviews in serious cases where other evidence, for example medical records, alone will not give a complete picture of what happened, and enabling us to weigh up evidence from all parties involved; and
  - e. delivering an investigation as quickly as possible.
212. We recognise that there is still much to do and we have work planned to help us:
- a. listen more to what people want from a complaint in order to help us make sure we investigate what really matters to people;
  - b. continue to improve our communication with both complainants and the organisations we investigate; and
  - c. continue to improve how we explain our decisions and how we have considered the evidence that we used to reach them.

*iii. Evidence and impact of changes*

213. We will continue to collect feedback from people who use our service , use quality checks to measure compliance with our new standards and management information on aspects such as how long we take to conclude investigations.
214. We will publish that information online from the end of 2016 along with information about what we plan to do next to continue to improve our service.

## Annex A – The relevant standards

National Health Service  
Regulations 2009

[http://www.legislation.gov.uk/uksi/2009/309/pdfs/uksi\\_20090309\\_en.pdf](http://www.legislation.gov.uk/uksi/2009/309/pdfs/uksi_20090309_en.pdf)

The NHS Constitution for England  
- what it says about complaint and redress

<https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england>

The Ombudsman's *Principles of Good Complaint Handling*

<http://www.ombudsman.org.uk/improving-public-service/ombudsmansprinciples/principles-of-good-complaint-handling-full>

## Annex B – Observations on the Child Death Overview Panel Process

1. The Child Death Overview Panel has no investigative function. The purpose of the Child Death Overview Panel is to provide a mechanism for professional learning from incidents of child death. It is not intended to be a safety net to scrutinise individual cases and the evidence gathered. This is why it is anonymised.
2. The Child Death Overview Panel is a review and cannot be held responsible for the information it receives. The panel should be accountable for the effectiveness of its reviews but any organisation reporting to the panel is responsible for providing the most accurate information available. The Child Death Overview Panel is accountable to Ofsted as part of its reviews into local safeguarding and is the responsibility of the Department for Education, which also has a responsibility for children services.
3. The Child Death Review Meeting is a local case review, which reports to the Child Death Overview Panel and is not arranged or co-ordinated by the Child Death Overview Panel. It is part of the local overview process, and in this instance was arranged by the Trust hence it is included in this report.
4. Guidance issued for the Chair of a local case review states that a completed Form C should be supplied to the Child Death Overview Panel, together with summary notes of the meeting, and a completed recommendation sheet. The Chair should prepare a letter for those present, a proforma for the coroner, and most importantly a letter for the family.
5. The Chair should be independent and must not have been directly involved in a patient's care. Working together to safeguard children (March 2015) recommends that where possible enquiries as part of the child death review process should not be led by the clinician who was responsible for the care of the child. This was not in place in the 2010 version but it is an understandable expectation.
6. Recent updates in policy and procedure have taken place in relation to the Child Death Overview Panel that deal with some of the issues that arise from events that occurred in 2011.
7. We note that a recommendation in the new guidelines is that the clinician responsible for the care of the child should not lead any subsequent investigations into that care. This is good practice and provides a good base for conducting the panel's business in an independent manner. However, we question whether the current guidelines go far enough in order to protect the integrity of the process. Were the guidelines to state that the Chair of the Panel MUST not have been involved in the case being reviewed, it seems to us that the impartiality of the process could less likely be questioned. We also note that in the new guidelines a recommendation has been included that families are invited to be involved in meetings as appropriate. We agree that family involvement is vital in such investigations wherever possible.











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