From the Ombudsman Robert Behrens CBE

Parliamentary and Health Service Ombudsman

Rt Hon Steve Barclay MP
Secretary of State, Department of Health and Social Care

Sent by email only

23 August 2023

Dear Secretary of State,

The murder and attempted murder of vulnerable newborn babies by Lucy Letby marks a dark moment in the history of our National Health Service.

As you know, the NHS is staffed by dedicated, remarkable people who want to make a positive difference, and we should not forget that Lucy Letby alone is responsible for committing these hideous crimes.

I note your announcement of an independent inquiry into the events that took place at the Countess of Chester Hospital NHS Foundation Trust. However, along with many others I agree that the inquiry should have statutory status. Only a statutory inquiry can provide the strong legal powers necessary to compel witnesses and the release of evidence. The inquiry should have all possible levers available to it to get to the truth. The families involved deserve no less.

Time and again we see mistakes repeated across the NHS and the system as a whole is not learning from this experience. We cannot let the environment in which Letby was allowed to perpetrate her crimes emerge again. What we heard during the trial was a culture of defensive leadership, a leadership that was more concerned about reputation than patient safety.

Clinicians were not listened to when they raised concerns. They were silenced and treated as troublemakers, and threatened with disciplinary action.

Although the appalling actions of Lucy Letby are extremely rare, unfortunately, the culture of fear in NHS trusts is not isolated to this case. Leaders dismissing the concerns of staff is a pattern of behaviour that we see repeated across the NHS. I see it in our casework. It is a feature of a number of independent reports into Trusts across the country. I hear it when I speak to medical professionals. Some still pay a heavy price for speaking up and this victimisation discourages others from coming forward. It is unacceptable and against the principles of what the NHS stands for.

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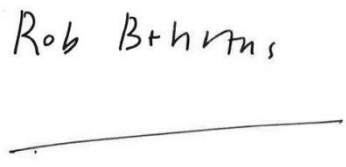
I wrote to you earlier this summer to highlight the recommendations of our latest report on patient safety, *Broken trust: making patient safety more than just a promise*. In the light of recent events, these take on even more urgency and I am reiterating our calls for the following:

- A thorough review by the Department and Health and Social Care and NHS England to scrutinise the lack of compliance with the Duty of Candour. It is unacceptable that Trusts still fail in meeting this duty nearly a decade after it was introduced.
- The Department of Health and Social Care should commission an independent review of what an effective set of patient safety oversight bodies would look like. There is widespread agreement that the current landscape is too crowded and confused, with significant overlaps in function that create uncertainty about who is responsible for what. This must be tackled head on.
- A clear commitment to embedding the culture and leadership needed to ensure patient safety is always the top priority. This means addressing the problems of defensive leadership that are still too common across the service. I respectfully urge you to conduct a thorough, independent review with cross-party support of NHS leadership, accountability and culture. While we acknowledge the findings and recommendations from previous important reviews following major failures in the health system, this is the moment to truly reset the culture of the NHS which can only happen if we fully explore the problems and potential solutions. As such, this review should explore how leadership is accountable, can be regulated and held to the highest standards in the same way as clinicians.

I would welcome the opportunity to meet to discuss these recommendations in more detail.

Yours sincerely,



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Ombudsman and Chair

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