Transcript of Radio Ombudsman #9: The Ombudsman's annual lecture at the London School of Economics

At the Ombudsman's annual lecture in December 2018, Sir Liam Donaldson, former Chief Medical Officer and patient safety expert delivered his presentation on 'Avoiding the avoidable: Comparative Approaches to Patient Safety'.

Ombudsman Rob Behrens then spoke about our role and how we can work together with regulators, organisations and people who use our services to improve patient safety.

This was followed by questions from the audience.

Simon Bastow: Good evening ladies and gentlemen. Welcome, a very warm welcome to the LSE on the occasion of the second annual lecture of the Parliamentary and Health Service Ombudsmen.

My name is Simon Bastow, I'm a member of the faculty at the School of Public Policy. The School of Public Policy is a relatively new institution, launched a couple of weeks ago. We have run, for many years, a master's level postgraduate education in public administration. A master's in public administration and executive training.

I suppose, at the core of the school are the values of training current and future policymakers in a couple of things really. Firstly, to understand the use of evidence and analysis in policymaking. Also, to get them to understand the craft of government in engaging with particularly difficult and complex issues, and the interplay between the political, the cultural, the legal, the administrative and managerial, the technological, and the human element in all of that.

The topic of tonight's discussion, I think, has all of these things in abundance. I'm very privileged to be able to chair this session tonight. On behalf of the school, we're very pleased that we're able to host this annual lecture on behalf of the ombudsman.

The title of the lecture, tonight, 'Avoiding the avoidable: Comparative approaches to patient safety.' It's a great pleasure to introduce the two speakers that we'll hear from tonight. I'll start with Rob Behrens, he doesn't need much introduction as the current ombudsman. Anyone associated with the organisation, obviously, knows that already.

Rob has a very illustrious career, starting out in the civil service, senior civil service. He followed a path into the world of redress around 2003, 2006, and became the complaints commissioner for the Bar Standards Board. Then followed a path towards becoming an independent adjudicator, I should say, for higher education in the UK. It's widely held that Rob's work at the independent adjudicator was transformative and had a huge

impact during his time there. Of course, he was appointed as Parliamentary and Health Service Ombudsman last April. April 2017.We'll hear from Rob in a while.

The author of tonight's lecture, Sir Liam Donaldson, has been described as a global leader in areas of patient safety and healthcare systems. Often the term 'global leader' is much overused or lightly used but it seems, in this case, it's entirely appropriate for many reasons. I think anyone following themes of patient safety throughout the last few decades would recognise Sir Liam's name and reputation.

Appointed as Chief Medical Officer in 1998, in the early years of the Blair Government, he served in that post until 2010 under two prime ministers. I think I calculated about seven or eight Secretaries of State for Health, so extreme resilience for that. Throughout his term, he's known for some impactful transformation changes in the system, not least with the introduction of the smoking ban in public places towards the end of the 2000s. Fundamentally, I think, putting in place machinery of government to deal with patient safety issues across the British public sector.

Since 2006 Sir Liam has been involved with the World Health Organisation in highly impactful ways, a member of the executive board and vice chairman. Also, more recently, the work he's done as a global envoy for patient safety on behalf of the director general of the WHO… Leader of the World Alliance for Patient Safety as well, so a global leader in every sense tonight. It's a great privilege to invite him up to speak in a few minutes.

The format tonight, what we'll do is Sir Liam will speak for about 40 minutes and then Rob will make some remarks in response for about 20 minutes. I'm very keen to open it up to questions as soon as possible. Hopefully everyone will have a chance to ask questions and to interact. I think we should just get going. Let me invite Sir Liam Donaldson, thank you very much.

Liam Donaldson: Thank you very much Simon, good evening everybody. There are four main conclusions to my talk tonight. The first is that the scale of inadvertent harm in healthcare systems around the world, including the NHS, is high. Secondly, the sources of harm, whichever country you look at, are very similar. Thirdly, the methods available to reduce that harm are reasonably well established. Fourthly, the level of harm has been relatively unchanged for three decades or so.

Let me start with one of the simplest ways in which somebody can come to harm. I've chosen the most vulnerable of patients, the new-born baby. I'll be talking about a few examples of clinical cases this evening, all of them are in the public domain so I'm not disclosing any confidential information that hasn't already been reported in coroners' inquests and other public documents.

This little baby, Madison Emily Perry was born in a hospital in the United Kingdom. She had a serious congenital heart defect, but one that would be very treatable by modern cardiothoracic surgical techniques. She was treated with the full battery of drugs and machinery that would be given to a child in this situation.

She was given one of the commonest drugs used in this sort of surgery, and in other surgeries as well. A blood-thinning drug called heparin by an intravenous drip. She was prescribed 1,500 units of heparin by the junior doctor that was overseeing her care postoperatively. The prescription was written like this, using the standard international abbreviation for a unit. It was interpreted like that. The final symbol there, the U, was interpreted as another zero and she was given 15,000 units of heparin and died. That error, or one like it, has occurred, not commonly but regularly, both in this country and around the world since the 1960s.

When I was chief medical officer, I spent quite a bit of time on the patient safety strand of my work. As Simon said, I also did public health and various other things. One of the things I did do was that I met victims of harm, both patients and families who've suffered harm. Then I was accused, by the Civil Service, of micromanaging. That was the term that was used. I didn't consider it as micromanagement. I was reasonably good, I thought, at strategy. I did believe, and still believe very strongly, that understanding the granularity of situations in healthcare is very important if you want to try to do anything about it at the strategic level.

I pictured myself in my older form, here, more up to date than some of the photographs that are used in conference material. What I was doing here was, I was going back to some of my old files. I did this a few weeks ago. What I used to do was, I would spot cases of harm or deaths due to healthcare in the media. There were rather a lot of them. Then I would ask to speak to the family or relative, if they were willing to talk to me about their experience.

I just put some of the headlines, in my old file here, up on the screen. I've got one point in particular to make about this.

These are the sorts of things that you still see in, particularly the tabloid, newspapers on a regular basis.

Here is a six-year-old boy in 2009, one of the old sets of cuttings I've pulled out, killed by a tumour. "Boy sent home eight times." So that was a case of a misdiagnosed brain tumour. A mother died after consulting eight general practitioners in four days, unrecognised blood poisoning or septicaemia. "Doctors ignored dying boy burned by a cup of tea." Again, a case of sepsis missed leading to death. "Blunder led to mother dying just hours after giving birth." In this case an intrauterine haemorrhage, a common cause of death in low-income countries in the world. "Hospital that forgot to tell a nurse she had cancer." Delay leading to metastatic cancer.

There are a significant number of people every year in this country, and other countries, who have a poor prognosis of cancer, not because of the aggressiveness of their disease but because their test results are lost or not followed up properly.

I give you those headlines as an example of the granularity of problems that exist. I do so for another purpose as well, that is to say that these things are still occurring, reported in our media, today. They are no longer regarded as a scandal. We, as a public, as consumers of the media, are largely inured to those sorts of things. We may feel a short period of sadness as we read it but they, with a few exceptions, are not reasons for the health service facing up to the need for transformation.

I've a second story. I've got three altogether. This is one that I've particularly majored on in my communication on patient safety. I show it for a number of reasons. The first reason I used to start showing it is because it's an example of a classic accident in healthcare. Everything that could have gone wrong, went wrong, the sorts of things that would bring a plane down. Multiple factors conspiring to bring harm, and death in this particular example, to the patient.

As I've been telling it, it's almost as if the story has got a life of its own. It has given new information, which I hadn't expected whenever I started telling it.

It's the story of a 16-year-old boy, Wayne Jowett. He was a teenager living in Nottingham, England. He was suffering from acute leukaemia. When I was a junior doctor probably about 5% of children survived, now something like 90% of children survive. So a major therapeutic triumph for medicine, at least in the developed parts of the world.

Wayne was a rebellious teenager, so his mother told me when I met her in my office in London. He was unwilling to go up for his treatments, he had them regularly. The only person that had

influence, the major influence on most rebellious teenagers, was his grandmother. She persuaded him to go up to the hospital. They went up together.

The staff were very, very, keen that he shouldn't miss his treatment. He didn't have an appointment, so he was taken out of sequence. As some of you who have studied accidents and safety… That is one big risk, to be out of sequence in a procedural sense.

He needed two sorts of injections. He needed one drug given into his vein, an intravenous injection, and another drug given into his spinal fluid, an intrathecal injection, a standard treatment in the chemotherapy for leukaemia. You will see that one of the syringes has a clear warning on it, vincristine is the drug. The warning on it is, "Not for intrathecal use." In other words, "This is the one that should be given into the vein." Definitely not into the spinal fluid, the warning is there.

What happened was that Wayne was given his procedure. To cut a very long story short, he was given the intravenous drug intrathecally. He became paralysed and, over a period of about five days in the intensive care unit, he died quite a painful death.

I talked to his mother, and father and grandmother, in my office in London. His mother told me that when they went up to the clinical area, having been called to the hospital, they saw his regular paediatrician, who'd been looking after him, who said, "There's been an error, but we think he's going to be alright. He'll be taken to the theatre and it will be washed out of his spinal fluid. He should be okay."

They then encountered another doctor, that they didn't know, who said to them, "Prepare yourself for the worst, your son is going to die." His mother told me, as the situation developed… He went to theatre, he had it washed out, it didn't make any difference. His condition was deteriorating. The worst part of it was that the first question he asked her, when he regained consciousness in intensive care, was, "Mum, am I going to die?" She told me that this was the worst moment of her life, to tell her son that he was going to die.

Wayne had this error perpetrated on him for a number of reasons. The two syringes, as you can see, could easily be confused. They came to the clinical area in the same plastic bag. They were supposed to be transported separately. A senior doctor was supposed to come down to supervise the procedure. He was telephoned and a post-it note was left on his desk, which he didn't see. So the supervisor didn't come down.

The two junior doctors who gave the injection, one of them had done one before and one had seen one before. They were, on an induction period, not supposed to treat anybody. Because they were so worried that he hadn't had his appointments, they stepped forward as, if you like, good clinical citizens to try to help out. Then there was a mix-up and the wrong drug was given.

When I saw this case, originally, I asked, not a royal college to investigate but, an accident investigator who'd previously investigated rail crashes and things of that sort. He did something which is never done in NHS investigations. It may be now, but I don't think so. He reconstructed the incident, which was at the time a novel approach. His report is in the public domain. He found 30 system failures. Things that came together, including some of the ones I've mentioned, to kill the boy.

A very tragic case, at the time there would have been 50 in the medical literature. One of which I've told you about. In this particular case, the junior doctor concerned was put in jail for manslaughter. Then there'd been another case, a couple of years earlier, in a hospital about 40 miles away from this one. The doctor had been quietly counselled behind the scenes and allowed to carry on with his practice.

Some of the patient safety literature talks about the second victim. Our principle concern is, of course, for the patient that's harmed, but there is also harm for the staff involved.

I'm going to show you a short video clip now. This is something which has been put together and has been shown very widely around the world as an educational tool. It's a very short clip. I've got one request of you as you watch it, which is… The great rock guitarist, Keith Richards, was once asked, when he's on stage doing his guitar solos, what does he think, what's going through his mind. He said, "I don't think, I feel." I'd like you, as you see the doctors here, or the patients, to try to feel how they might be feeling, either the patient or the doctor in this situation.

Let's just go through it. I've got to press a separate button to get this going, but then…

[VIDEO CLIP]

Male 1: Is that okay?

Male 2: Okay, that's fine.

Male 1: Vincristine, 2mg in 2ml.

Male 2: Right. Okay, that's it.

Male 1: Have you got a plaster?

Male 2: Excellent.

Female: Sorry to hold you up. You can't have finished already?

Male 2: Yes, we have, yes.

Female: I've got the methotrexate. So what have you given her? Oh my God.

Male 2: Can someone call Doctor Munroe please?

[VIDEO CLIP ENDS]

Liam Donaldson: I must have seen that 100 times, and it still sends shivers down my spine. Maybe it's because I can imagine myself in that clinical situation. There is a wider point here. This is obviously a specific reconstruction of the situation I've shown you. Most of our education is based on technical factors, knowledge. Of course, these days, communication and softer skills are taught.

We know, from our evaluations, that sort of granularity, explained to people or shown to people in that way, has an enormous impact. Students around the world have seen it. The anecdotal feedback I've had is that some have said, "We dedicate our practice to stopping this sort of thing from happening." So there is an angle there, as well, which is wider than, perhaps, the specific example.

My mother was a great Agatha Christie fan. She used to say to me, "Liam, there's a great one here. It's got a twist in the tail." I don't know if you remember that old expression. I never had time to read the books, but she was always pressing them on me with that request that I should read them because of the twist in the tail.

This story has got a twist in the tail. I've told you about the one example. Fifty in the medical literature at the time that we first looked at these vincristine errors. One week, we heard that there'd been 100 more cases. So 50 over 30 years, worldwide, documented. Then, in 1 week, the number went up to 150. Can you think why?

What happened was that a Chinese drug manufacturing company was manufacturing these two drugs on the same site, the intravenous one and the intrathecal one. There was a contamination, rather like peanuts can contaminate other foods, as a result of which there was an epidemic of these intrathecal errors in China.

This was a company that was exporting to the west. These particular drugs weren't exported, but most of their other

products were. Had they been exported it would have not just been an epidemic in China of 100 cases, it would have been a worldwide pandemic. For something that started off as a rarity… The upstream implications of this, which we would never have thought of as a causation, would have… Well, did cause a catastrophe in China.

Then there was a second twist in the tail of this story. A pharmacist working in America, hearing about the work we'd done in England on this, sent me a journal article from a neurological journal. For a rare neurological condition, the authors recommended treatment with intrathecal vincristine. Completely unknown to them, which is well-known in the patient safety literature, the toxic effects of it. They recommended that as a treatment. Then the journal redacted it and withdrew it.

So that simple story of the classic accident, 50 cases, showed it had much more to tell us about the pervasiveness of risk in healthcare.

My final example, before I start to sum up with some points. This gentleman, Maurice Murphy, was a very talented musician. He played on the soundtrack of Hollywood films like Star Wars and Harry Potter. He went into a London hospital for relatively routine treatment. He didn't come out alive, not because of his disease but, because he had a particular procedure which is quite common in hospitals, the feeding of somebody through a nasogastric tube.

It's threaded down through their nose into their stomach, whilst they're not able to take food by mouth. Then feeding fluid is injected through, down into the stomach. Before you can do that, you need to check that the tube is in the right place. There are standard ways of doing that.

Mr Murphy was in hospital. My account, which is going to be brief, is drawn directly from the coroner's inquest. When I quote, I'm quoting verbatim. What happened was the tube was placed, an X-ray was taken to confirm it. The order was given that the tube was in the right place and that the patient should be fed.

A junior doctor was supervising the ward that night. He came on his rounds and found that he hadn't been fed. He said to the junior nurse, who was on the ward, "Why hasn't he been fed?" She said, "I'm uneasy that this tube may not be in the right position. I didn't want to feed him thinking that, my uneasiness about it." He got the X-ray and looked at it again, he said, "The tube is correctly placed, please feed the patient. I will come back in a couple of hours and check on his progress."

He came back in a couple of hours, the patient still hadn't been fed. This is the verbatim quote. The junior doctor said to the nurse, "You don't have a brain to understand what I said, feed the patient." The patient was fed, the fluid went into his lungs and he died.

When we think about these things… I could've done this for the Wayne Jowett case. The very celebrated metaphor that's used right across the whole field of safety, in all industries, was invented by a now retired academic at Manchester University, James Reason. It's the Swiss cheese metaphor. His idea is that in a well-protected system, safety-wise, the slices of the cheese should be solid. There should be barriers protecting the patient or the airline passenger or whatever it might be.

I've given some examples here. There should be strong procedures, the staff should be very professional, there should be a team culture, good training, good communication.

In this particular case… If anything goes wrong the cheese moves from being slices of Cheddar to slices of Swiss cheese, the holes and the vulnerabilities start to line up. In this case the gaps in the defences were that procedural guidelines weren't followed and there was an inappropriate attitude, as you heard, a hierarchical attitude.

In any industry, safety-sensitive industry, hierarchies are very, very, very, bad. They're bad in healthcare, people frightened to speak up. There have been planes that have flown into mountains, notably Korean Airlines during the 1970s, where the hierarchical attitude in the cockpit meant that the junior pilot, even though he could see the plane was flying into a mountain, didn't feel able to challenge the pilot.

In healthcare it's just the same. If a junior nurse can't challenge a junior doctor, or a junior doctor can't challenge a consultant, even when they see things are going wrong, that is a bad culture. It's too common in healthcare.

Then, obviously, there were other features, as well, in this particular case. Has it helped, this death? Well there has been some improvement, but in the period after this gentleman died there have been 95 further incidents in the NHS and 32 deaths. Things have not necessarily got any better, little has been learned out of such an incident.

When we think about safety, the jargon 'systems' is usually used. Essentially, when something goes wrong, it's due to human error but usually human error that's provoked by something in the system. Either a machine that's difficult to understand the calibration, two medicines with different effects that are

packaged in the same colours and the same packaging, all sorts of reasons why.

A recent study in the NHS showed there are 200m errors in medication use every year in the NHS, 200m. It's because of these interactions between people, machines, procedures, in, often, a physical and social environment that's very complex and fast moving.

Our chairman mentioned the question of resilience. It's a really good term, and it's where a lot of modern thinking is going in healthcare. It's about trying to build organisations and procedures and services which are resistant to harm.

These are all the incidents that are reported in the NHS every year. This is a recent cumulative list of them. You can see that the deaths and severe harm are at the top of the pyramid, those are the only ones that are ever analysed. That's different to other high-risk industries. In other high-risk industries, one of the wisdoms is that you learn a lot from the things that went wrong but nobody was harmed. There are more of them, and they're interesting.

What I thought I'd do, and I did this about a year ago, I've pulled out from this bottom category a no-harm incident report. This was made by a nurse. It goes like this, "Commenced the night shift short-staffed." This is verbatim. "Doctor in charge was a locum, newly qualified, and unable to administer intravenous medications. Registered nurse is an agency nurse, only saw 2 out of 10 patients, department overfull with many patients on trollies. Shift was unsafe, unsafe, with reduced numbers of staff who were inexperienced and lacking skills." That's a no-harm incident.

There is a very nice book written about resilience in all high-risk industries, called Managing the Unexpected, by Kathleen Sutcliffe and Karl Weick. They have a number of criteria for a resilient organisation. One of the ones that I like most of all is expressed like this. "A high-resilience organisation, a safe organisation, is one which makes a strong response to a weak signal of failure."

In my view that is a weak signal of failure because it's right at the bottom of the pyramid, nobody would ever look at it. If you were on top of your game in safety and resilience, you would be responding strongly to that. If I read that before I went into hospital, I wouldn't go near the place and I wouldn't have any of my… A nurse is saying it's not safe to go there, but yet people are happily going there totally ignorant about the fact that reports like this are being made.

If we want to do something about it, the experience from other industries is that you get the greatest payoff if you can come up with solutions that are at the top of that slide. Things like education, and giving people guidelines and information, do improve things but they're relatively weak. They make a relatively weak impact compared to standardisation, checklists, and things of that sort. That's what the evidence shows.

If we take an industry that's been enormously successful compared to healthcare, the airlines have got safer year on year on year. If you fly on a scheduled airline tomorrow, your chances of dying are something like 1 in 12m. Research shows that if you're being admitted to a hospital your chances of being subject to a very serious error are 1 in 300. Not a bad comparison, is it, 1 in 300 vs 1 in 12m. The reason that these other industries have done so well is that they do things differently.

Things that other industries, like the airline industry, do differently, they know their risks. I've asked numerous clinicians and managers if they can talk to me about their risks. They usually start on about the financial risk things that are discussed at the board meetings. Very few clinicians have a good understanding and can scope the risks in their subject area.

They investigate much better, in a way that results in learning. That's the test of a good investigation, does it give us material that we can action and will prevent the same harm happening to the next patient? They tend to use standard operating procedures a lot more, that's an anathema to medicine. Doctors don't like being controlled. I'm a doctor, I know how they think. Standard operating procedures would probably save quite a lot of lives, but they're not generally used.

If we had a slogan for describing how we approach education of health professionals in this country, it would be, "Educate in siloes and practice in teams." Ironic but true, that is what we do. Yet we expect people to work in a team.

The beauty of watching the Formula 1 teams or many other teams, it's beautiful to watch them. They come together instinctively, they've been trained, they know how to interact. In healthcare, the teamwork works reasonably well but not to the same level that you would achieve if you were training more effectively in that way.

The use of simulators which, to some extent, are being used now in surgery. This is the flight, if you remember, a few years ago coming in from Beijing. The co-pilot was called Captain Coward. He wasn't a coward because he managed to land the 777 in very, very, difficult circumstances like Sully Sullenberger, the miracle

on the Hudson. They were both asked, “What did you think when you were flying in?” They both said, “We felt we were in a simulator.” That’s why they landed the planes safely. The opportunity is there to train for accidents. It’s hardly ever done in healthcare, but the technology is making that possible.

I’m going very strategic now, and looking… I’ve just got a couple more slides to show, then I’m finished. If we were looking at, at a very high level, the things that would drive this safety agenda into the right place, I think we’d be looking for compassion, we’d be looking for the sort of reaction, to some of the patient stories that you’ve seen, that you feel tonight and I feel even as a presenter. You would want that compassion to be there in every corner of the healthcare system every day.

You would want passion, you would want people saying, “Yes, we’re going to go for it. We’re going to beat the airline industry, we’re going to show we can improve year on year.” That passion isn’t there for a variety of reasons, it’s not part of the education, it’s not part of the leadership profile of people.

Then, obviously, there are technical things, investigative methods and other improvement methods, which would come into play as well.

A few years ago I was sitting in the bath in London, which is something I don’t do very often these days, it was a good place for creative thought. My wife was out for the night. I was prohibited from using her Chanel No 5 bubble bath. On this occasion, as she was out, I managed to take a small sample of it and get a nice bubble bath to promote the creativity. My grandmother used to mark the whiskey bottle. She didn’t do that with it, so I think I probably got away with it.

I came up with this little dream, daydream, which was that on the tarmac somewhere in the world there was sitting a Boeing 757. In its pre-flight engineering inspection, the engineer noticed that an orange coloured wire had come off the housing. He or she would obviously replace it, solder it back and check it and everything.

My daydream, and I think it’s more like reality, is it probably wouldn’t have ended there. There would have been a worldwide, global, alert and all engines of that type would have been checked. I call that the orange-wire test because it was an orange coloured wire. There is no way in which healthcare systems around the world are anywhere near passing the orange-wire test. Even hospitals in the same town don’t learn from each other.

In my work with the World Health Organisation, only last year, I spoke to a woman from South Korea whose son had been killed

by an intrathecal error. This is 10 years later than Wayne Jowett, after numerous articles and guidance have been sent out worldwide. The physicians in the hospital concerned were not aware of this particular risk.

I mentioned James Reason, this was one of the nice things that he said to sum up a lecture like this. “Either we manage human error, or human error will manage us.” Thank you.

Simon Bastow: Rob, would you like to…

Rob Behrens: Sure. First of all, thank you LSE, thank you Simon for hosting this second ombudsman lecture. Thank you to Liam for such a thoughtful presentation. Everyone here is grateful to you for your contributions to patient safety over the years, not only as chief medical officer but your role in the World Health Organisation.

As part of my ambition to reform the national ombudsman service in the UK, I appointed Sir Liam to act as the independent advisor to review the way we, as the national ombudsman, use clinical advice in our casework. This big study is chaired by Sir Alex Allan, who is in the audience today. It’s a study which has involved a lot of consultation. It’s still in preparation, it’s too early to announce what it’s going to conclude. It’s part of a two-pronged approach to make sure that we rise to the challenge which has just been described.

The first prong in the process was to commission an independent expert review of the Ombudsman Service conducted by the National Ombudsman for Ireland, Peter Tyndall, who completed his work in November. That has been published, and is on our website.

What I know, from both studies, is that we have a very long way to go to get things right. There are certain things that we, as the national ombudsman service, can do. Structurally, if we’re going to rise to the challenge which Liam has set out, we will need legislative change. To change the nature of how we engage with complainants and with patients in order to be able to deliver on the three elements that Liam describes, compassion, passion, and technique. We’re campaigning for that, though the present circumstances make it very unlikely that we’re going to get reform very quickly.

As the independent ombudsman service, the challenge for us is to deal with the many thousands of complaints that we get from people across the country.

We're different from other ombudsman schemes around Europe, and in the world, in that there is a heavy bias, in the caseload that we have, towards health service issues and away from the original conception of this service which was to deal with parliamentary issues. This is a problem because it means that we do not have international counterparts to rely upon in order to benchmark ourselves and to be able to make suggestions about how we can go forward. So that's the first thing, our evidence base is large but we are untypical of other ombudsman services.

We received, last year, 25,000 complaints about the NHS. We had inquiries from 123,000 people who spoke to our intake team on the telephone. The independent review, conducted by Peter Tyndall, found that we do an important job in giving advice to these 100,000 people about what they have to do in order to attempt to resolve their complaint. Because of the absence of a common portal which leads one path to the ombudsman service, we're dealing with a vast majority of people who have complaints that we are not able to deal with.

They are either premature because we're a classic service and we can only look at issues once they've been looked at by the body in jurisdiction. Or because they are outside our remit. This is very frustrating, not only to our people on the telephone but also to citizens who don't have a particularly good understanding of what an ombudsman does or is, and who expect us to be able to deal with the issues that they are raising.

This is a challenge. I know, from my recent visits to Europe, that the public recognition rate for the national ombudsman service in countries like Austria and the Czech Republic - because of their ability and the powers that they have and their access to state television and so on – is over 70%. Whereas for one reason or another, and I'm not particularly interested in going into that now, the public recognition rate of my organisation is less than 20%.

It's not easy to be able to launch a public campaign and encourage people to come to you when, in all likelihood, we're not going to be able to help them in the first place. In the second place they don't really understand who we are because of the perverse name, Parliamentary and Health Service Ombudsman, and because they don't understand the concept of what an ombudsman is.

It's hard to be able to map a way forward when there is only one other European ombudsman service that deals with health service complaints in the way that we have to do. Only, outside the United Kingdom, in Spain is there a systematic look at health service complaints for us to be able to interrogate what they do and how they do it. That makes it difficult because the

mandate, that we have been given, gives us a broad remit to look at maladministration. As is well-known, we specifically have a remit, a responsibility, to look at clinical issues and clinical judgements in the health service.

I'm pleased that we were required to reform our clinical standard by the Court of Appeal, and I'm pleased that we've consulted with stakeholders and with members of the public to make sure that we get the clinical standard, which is now in place, right.

I want to say two or three other things before sitting down. The first is that there is a connection between patient safety and complaints handling, but they are not the same thing. They overlap but they are not the same thing. In my view, complaints handling has come into disrepute over the years because it's been used as a way for people to have access to redress in a way that is not appropriate for issues of patient safety which have been described tonight.

Therefore I, with caution and a degree of scepticism, welcome the Government's approach to making sure that alongside complaints handling we have a separate, but related, way of looking at patient safety. Through the Healthcare Safety Investigation Branch, which is attempting to deliver many of the things that Liam was talking about in his talk.

It does that in a way which is not compatible, in itself, with complaints handling because it provides a safe space which effectively means that no one gets blamed, individually, for what happened. Therefore, there is no individual redress for those who are interested in the outcome. It does mean that the kinds of learning which are described in Liam's talk, and operate in the aircraft industry, will be available, and are beginning to be available, to the health service.

In my view, it would be a profound mistake to try to elaborate on that system by saying that it should apply to all issues in the health service, that it should become the main redress mechanism. Indeed, the draft legislation makes it clear that HSIB will be a body in jurisdiction so that we will have the opportunity of looking at some of issues that it's dealing with and we won't be silenced by the safe space. We want to work with HSIB. I have every confidence that we'll be able to do that, but we have to understand that we're doing complementary but separate things.

There's also been pressure from Government to reform the ombudsman system, in recent years, in a way which I think is extremely unhelpful to the agenda that Liam Donaldson is talking about.

There has been a dumbing down of the concept of the ombudsman to become, effectively, a consumer rights body which is going to provide redress to people who have issues with the way in which they've sold goods or financial services. That, altogether, ignores the critical role of the ombudsman, which I fight for because I believe it's absolutely right, to be able, if we do it properly, to call public bodies to account in a way that citizens can see that there will be change as a result of changes that are made.

In the last two years, I am pleased that PHSO has published insight reports on issues around mental health, around eating disorders. Next week, in Parliament, on whistleblowing in the NHS, which is a very big issue. We've done that in a way which contributes to the learning and the policy development, which it's essential that an ombudsman contributes to if they're going to live up to the name that we're talking about. A just culture, a non-hierarchical health service, has to emphatically improve the way it treats whistle-blowers if patient safety is going to operate effectively.

I have to say that one of the things that has shocked me, as ombudsman, is the number of clinicians who have been to my office in private and have said, "I would like to make a complaint, but I know that if I do I will lose my career. Therefore, I can't do it." Because we do not have, as 75% of world ombudsman have, the power of own investigation, to be able to decide what we investigate, that means if people are not prepared to complain there is nothing that I can do about it. I think that is profoundly wrong in terms of public policy.

I want to end by saying this. I accept that communication is absolutely at the heart of what we should be doing. PHSO, as an organisation, has not got this right, emphatically, in previous years.

Everything that we are doing now is about improving the quality of the training available to our case handlers to make sure that they're capable of dealing with bereavement, trauma, distress, despair, which is part and parcel of dealing with the National Health Service. Unless we can do that — and unless we can live up to the standards which Scott Morrish, who is here today, has talked about in his contributions to these questions about taking seriously, and really listening to and acting on, the views of people who are distressed or are bereaved — then we're not going to be able to live up to the proper standard of what an ombudsman should be doing.

It's our responsibility to deliver that training for the people who have the difficult task of dealing with people on a daily basis.

My last point is this, in the United Kingdom and in the health service, I am constantly told by people like Shaun Lintern that there is over-regulation. Too many regulators, too many bodies setting out standards. That may be true, but it's what we have at the moment. The critical task of regulators and ombudsman is to make sure that we work together, without losing our independence, to address the issues that one body alone cannot address. Thank you very much.

Simon Bastow: Thank you Sir Liam and Rob. Okay, well I'm very keen that we get the microphone out to the room. It's a very nicely shaped discussion, this, in that we have the front end and the issues of patient safety, and the back end, the investigation of failure and redress processes. It seems to me that it's a good opportunity to investigate how the two can potentially be integrated in constructive ways. In many ways they both face the same challenges, cultural change, legal constraints, communication challenges and so on.

Let's just get the microphone out there. I'm sure that there are many questions waiting to be asked. Asma, you have the microphone. Anyone would like to kick off questions, hands up?

We'll take three questions as clusters and then go with that.

Mick King: Hi, I'm Mick King, I'm the Local Government and Social Care Ombudsman. I deal with very similar issues in the social care space in particular. As Rob has highlighted, as ombudsmen, we pride ourselves on not just resolving complaints in a transactional way but trying to draw out lessons that are going to drive service improvement and make recommendations to improve services.

I just wonder if you had any observations back to us about how our decisions land in the health service or in social care, and whether we actually achieve what we want to achieve. Whether you can give us any pointers on how we can frame our feedback in a way that's going to link into the cultural issues that you've identified?

Della Reynolds: Hi, my name is Della Reynolds and I'm from PHSO the Facts. I put a complaint into the ombudsman, so I'm a service user. We've heard from Sir Liam that the same mistakes keep happening again and again, and it's kind of normalised now. We don't even consider it to be a scandal, which is shocking.

We've also had a health service ombudsman for about 25 years now. I want to ask why isn't the learning happening, why aren't we sharing the learning from the reports?

The point I'd really like to make, to follow up from what Mr Behrens said, is I feel that he undervalued the importance of personal redress. Personal redress is vital if you are a complainant, you cannot move on with your life without personal redress. Could we not have personal redress and learning in the investigation reports that are disseminated out into the NHS? I don't see why you can't have the learning inside the investigation report. Why isn't that happening?

Simon Bastow: Thank you. I should say, yes, could you say your name and where you're from.

Matthew Lee: Thank you, my name is Matthew Lee. I'm on the board of the Medical Defence Union. We were involved in defending the case that Sir Liam mentioned, the medical manslaughter case. We continue to defend doctors actively. Every month, almost, we're seeing another investigation that is on the verge of moving towards a police investigation. Several times each year, we're defending doctors with medical manslaughter cases. There are high-level cases, even currently, where doctors are going to prison because they've made mistakes.

I've been at the MDU, I think, for 19 years now. I've only seen one of those cases where I think it's actually been that the doctor has been sufficiently culpable individually, without system errors around them, to justify that type of investigation. I'd like to ask if there is a better way of investigating the actions of the healthcare team, short of actually pushing forward with medical manslaughter investigations, in the view of the panel.

Simon Bastow: Would you like to respond to that?

Liam Donaldson: Thank you, well I think they're great questions. I sound like an American, don't I? They're very good questions, thank you very much. The first two questions, I can't give you a recommendation for how learning and feedback could take place effectively. I can deepen the observations on why it doesn't happen.

You would think that when somebody died, and there was a clear-cut explanation for it, and it was to do with harm and

safety and errors, that that source of risk would be closed down immediately. That's what would happen in many other sectors. It doesn't happen in healthcare, not just in this country but around the world.

In fact, the way in which learning takes place is much more akin to the good practice side of medicine. If you study all the evidence on how improvement occurs in the treatment of hypertension, diabetes, things like that, it happens slowly and incrementally. Some people adopt it, some don't. Over time, it gets a bit better but very, very, slow… My observation on safety is the learning is much more akin to that than, if you like, the safety notice that would go up anywhere else. That's bad. You can say it's bad, but it's something to do with the deep-seated cultural attitude and values.

I remember, vividly, when I was chief medical officer, I used to like trying to get control of these situations. At one stage, we discovered that there were two sets of anaesthetic machines in the country. To cut a long story short, the old-fashioned Boyle machines, there was a way of turning them on and off which was quite high-risk. Patients had died as a result of it. It was a very simple safety measure. Basically, I persuaded the secretary of state to send out an immediate notice saying that all the machines had to be replaced. It wasn't that expensive. It took nearly two years for that to happen.

In the end, as chief medical officer, I was ringing up chief executive officers and saying to them, "You've seen the notice". I used a form of words that, recently, Arnold Schwarzenegger used about Donald Trump as a result of the meeting he had with Putin. I said, "What's the matter with you?" It's bizarre. That was such an easy technical fix. Much easier than some of the things that you would be recommending, which are to do with behavioural and cultural change.

So learning, in safety, is much more akin to the sorts of learning that occurs in other fields rather than in other fields of safety, if you see what I mean.

The second thing is, on this question of blame. I wrote an editorial for the BMJ last year saying that I didn't think that doctors should ever be accused of manslaughter, or very, very, rarely. I think the blame-free culture is sometimes misunderstood. I think there are rare cases where people have behaved wilfully neglectful when colleagues have said, "No, that's dangerous, you shouldn't do it". They've done it anyway. I see no problem about putting them in jail, but they would be great rarities.

Ironically, in the case you mentioned in… The Wayne Jowett case. The doctor was convicted on manslaughter. We'd lined up James Reason and Brian Toft, who did the report, all of them were going to tell the court, "This was a systems failure". The doctor was so stressed by the process, if you remember, that he pleaded guilty. That was why he ended up in jail. So the second victim side of things is terrible for people that are involved in those cases.

Simon Bastow: Do you want to say something in response to Mick's question? That would be helpful.

Liam Donaldson: I thought I'd answered that. I think that your recommendations go into the mix. They're not seen as anything special or exceptional. The most severe warnings are when the coroners send these section 40 letters warning. Even those don't have an impact, and those are kind of draconian warnings and very seldom have an impact.

It's back to this, the NHS is both overloaded with things it's told to do and inured to the risks of ignoring them.

Simon Bastow: How about Della's question on personal redress?

Rob Behrens: Yes. I think she's wrong. I do not think that an ombudsman, properly operating, undervalues personal redress. The issue for me is the evidence base that is required of an impartial decision-maker to come to a view, which is not the same thing as respecting the strongly held view of the complainant. If we are not impartial, between the complainant and the body in jurisdiction, we are not properly an ombudsman. In my view, the notion of a people's ombudsman is a contradiction in terms. That's not what ombudsmen do. That's not to say that we shouldn't be passionate in pursuing issues once we've found that there is maladministration.

Where I have a more sympathetic view to the point that she makes is that learning… In order to make an impact, you have to have certain elements present. The first is you have to be transparent, if you are not transparent… If you're not able, through custom or practice or law, to publish everything that you find in a particular case then you're not going to have the opportunity of embarrassing the body in jurisdiction when they say they're not going to be compliant.

I'm clear that moral authority of the ombudsman is overplayed. In my experience it's very often the threat of publicity, which would do damage to the reputation of the body in jurisdiction, which will be the thing which causes the body in jurisdiction to move. I have a lot of experience of saying to bodies, who are not compliant, "If you don't comply, we're going to publish." As soon as you say that, they change their view very quickly because they don't want the publicity associated with it.

The final point comes back to this. If we don't have the rigour of the evidence base associated with making the recommendation, if we are jolly amateurs expressing a view about what might have happened, we become irrelevant. That's why Liam's review is so important. Because we need to make sure that, on clinical issues, we have the competence in dealing with complex issues without losing our independence. That is very difficult to do, but it is achievable.

Simon Bastow: Questions? One at the back there.

Steve Powis: Steve Powis, National Medical Director of the NHS. Just a few comments, and then maybe a question to Liam. On section 28 reports, prevention of future deaths reports, not section 40. One of my jobs is to sign off the responses to all the section 28 reports that come into NHS England. I can absolutely assure everybody that I take that responsibility very seriously and I read, both, the coroner's reports and the responses that we provide to the coroners in great detail before I sign them off.

Only this morning, we were undertaking a thematic review of those that I've signed off since we started in January. I'm very keen that, not only do we sign off the detail of those individual responses but, we understand the themes that are coming through from the ones that are sent to NHS England.

This is so that we can absolutely assure ourselves that, in our patient safety strategy and in our national work on patient safety…which Aidan Fowler is leading as the new national patient safety director, who will be part of the new Joint Medical Directorate between NHS England and NHS Improvement…we understand what those reports are telling us, thematically, and we are ensuring that we are focusing, as a system, on interventions and programmes that will address those. So that was the first thing. They don't just go and sit somewhere, they do get looked at and they do get taken very seriously.

My other comment. I know the nasogastric case that you highlighted very well because I was the medical director at the Royal Free when that occurred at the Royal Free. I led the investigation and the learning afterwards. I can, again, assure you that a huge amount of learning and a huge amount of work to change our standard operating procedures went in after that. I won't go into the detail other than to say nasogastric tubes are a wicked problem and they're one of the things where I… What I would love is a technical solution that would give us a technical answer to when a tube is in the stomach.

The root cause of that case, as you alluded to, was a misinterpreted chest X-ray. One of the changes that we made at the Royal Free, after that, was to insist that X-rays for nasogastric tube insertion could not be interpreted by junior doctors. They had to be interpreted by radiologists. Of course radiologists can misinterpret nasogastric tube insertion, particularly where there are difficult anatomical issues around the stomach. I have seen that as well.

It's also the case that when you and trained what you used to do is put air down the tube and listen to the stomach. That's long gone. We tend to use pH, now, as a way of knowing that the tube is through an aspiration. There are cases in the literature when a pH below six has been documented and the tube still wasn't in the stomach, so it is a very difficult problem to solve. Only to highlight that some of those are difficult.

The question I was going to ask is about spread. I absolutely agree with you, one of the things that we need to do much better at is spread learning from one organisation to the next. I think there are a whole host of issues, including the cultural issues and human factor issues. I just wanted to ask Liam, in all the years that he's been doing this, what are the most effective methodologies for rapid spread of learning across organisations? What can be learned from other countries, in your experience?

Liam Donaldson: Just a small question to answer.

Scott Hislop: Thanks. Good evening, I'm Scott Hislop, I'm one of the principle national investigators with Healthcare Safety Investigation Branch. I come from a different background, and maybe bring a different perspective. I'd be interested to hear from Sir Liam, what do you think the levers are that we can really pull on within healthcare to change some of the deep-rooted culture that is probably engrained from the most junior doctors coming in, or the junior nurses, to change a system that is quite resistant?

Simon Bastow: Any more immediate questions? Yes, sorry, one on the end.

Alex Robertson: Alex Robertson, from the Parliamentary and Health Service Ombudsman. Liam, I took from what you were saying that the problems in approaching safety are probably not just particular to our health system but to health systems across the world. I wondered if you have any examples of countries or health systems which have got it much better than we do.

Simon Bastow: Any responses?

Liam Donaldson: Yes, I'll do them in the reverse order if I may. The safety in healthcare systems around the world, the best examples probably are in some of the larger health groups in the United States. Places like the Cleveland Clinic and Johns Hopkins, they are really mini health systems. Often there is a large teaching hospital, but then there are some hospitals and community facilities, some of them in other parts of the United States. They've got there, I think, largely through the quality of clinical leadership. The doctors and nurses, to some extent, are much more willing to take on managerial roles than, sometimes, they are in this country. That hands-on clinical leadership is one thing.

The use of data is another feature which is much less common in this country than it is in some of those demonstrations. The involvement of patients and families in the running of the institution, I could point you to four or five places in North America which are much better at keeping their patients safe than we are. They have features like that involved.

On the question of what to do about the deep-seated differences between us and other high-risk industries, the obvious thing to say is that we don't really educate people. As I said, we don't train in teams, we don't simulate situations. I would make another point, which is even more fundamental. When I first started this work on safety, and when I go to international meetings now, I say to people, "We are the enthusiasts, some of us are the academics, we are the people passionate about this. What's happening in the mainstream?"

I would say that the big difference between other industries, like the airline industry, and healthcare worldwide is that it's stayed largely with the enthusiasts and the academics, quality and

safety as well. It isn't lived and breathed by every member of staff, it just isn't. What percentage penetration there is, I'd be surprised if it was anything like 20% of people who had the sort of passion and the enthusiasm and the interest that you would see in other industries.

Then, quickly, on the spread across organisations, well I guess we have to go back to our friend, Rogers, who did the diffusion curve which you will be well familiar with. The early adopters then through the majority through to the laggards. Basically his message, from all of those studies, was that it's a social thing. It's to do with individuals influencing other individuals, rather than anything that we can do technocraticly to achieve change.

Simon Bastow: How about mechanisms like checklists?

Liam Donaldson: Yes, well that's standardisation of practice. That's definitely… Standard operating procedures – checklists - that would definitely help. As I said, in the lecture, that's not easily accepted. Though we did, through the WHO, introduce the surgical operating theatre checklist. It's helped, but it's not done properly everywhere. The anecdotal feedback you get, from different parts of the world, surgeons refusing, they say it's childish. People are filling them out in advance, before they even start the day. You cannot implement anything technical, like that, without the cultural change going in alongside it.

Simon Bastow: Can we get three more questions in before the end? Yes.

Maggie Brooks: Hello, my name is Maggie Brooks. I had a complaint with the ombudsman from 2011 to 2018 which, in the end, was unresolved. I walked away from it because I thought I was better off getting a second inquest than staying in the ombudsman system.

This could be my misunderstanding of how… As Mr Behrens was saying about how complainants misunderstand what the ombudsman can offer. Sometimes I don't understand the maladministration. If you're dealing with maladministration, which was always your major remit, why are all these deaths and injuries going to the PHSO?

Dame Julie Mellor said, "When someone makes a complaint, there is a wall of silence". Bernard Jenkin said, "If you make a complaint, the shutters come down". I believe, Mr Behrens, you

said something similar at that same meeting, “There isn’t really an NHS complaints system”.

That being the case, the PHSO is not the last resort for complainants about death and injury, it’s the first and only resort. People do come there with a feeling that they want more than a finding of maladministration. They want a thorough investigation of their relative’s death.

That is something the ombudsman cannot offer in the round. It cannot offer it because it isn’t set up to look at, to take into account… You may have been beside your dying relative, your evidence is not taken into account. So it’s not in the round… It’s not able… I don’t blame the ombudsman for not being able to do it, but I feel they should accept that they cannot deal with all these deaths and injuries without causing terrible distress to the people who have to hang on for eight years hoping somebody is going to investigate.

Fortunately, I’ve got a second inquest now. Hopefully that will bring the facts to light. Perhaps there will be a future but, eight years, come on.

Simon Bastow: Okay, thank you. Perhaps that relates to some of the legislative constraints? Any more questions?

Scott Morrish: My name is Scott Morrish, I had six years of experience of the complaints system. I just wanted to make an observation more than ask a question, actually. Which was that, with the Medical Defence Union in the room and HSIB and NHS England and the ombudsman, it’s quite a good room full of people alongside some complainants.

One of the inhibitors, as I see it, is fear in the system. That’s fear of hierarchy, it’s fear of regulators, it’s fear of shame when it hits the headlines. I actually think the system as a whole, including everybody just mentioned, needs to focus on getting the fear out of the system so that we aren’t forced into these sorts of adversarial contexts. In the context of the Bawa-Garba case, for example, letters are being sent to doctors telling them not to put reflections in writing as advice that helps them avoid those kinds of scenarios for themselves.

In my own case I know the Medical Defence Union told my GP not to talk to me, once it became a complaint, because of the possibility of harm that may flow from them. I think, really, unless the whole system can start pulling everybody in the same direction, in the interest of patient safety and staff welfare, to

make it open and actually safe to admit that stuff has gone wrong- "We will support you through the process that follows, rather than threatening you with punishment that could include prison or shame." Then, perhaps, we'd have a better chance of all of the components of the system having an easy ride in helping people like Maggie and Della and everybody else.

Ruth Dean: Hi, my name is Ruth Dean. I'm the Head of Patient Safety at a south London hospital. You've talked about how the Air Accidents Investigation Branch has managed to improve air safety. That has been because of a reduction in the hierarchy, flattening the hierarchy. I just wonder if you've any idea as to how we could possibly flatten the hierarchy within the healthcare system?

Liam Donaldson: Do you want to start off on this one?

Rob Behrens: Yes, I think I can be brief. Addressing the points made by Ms Brooks… Ombudsmen are no different from any other profession, in that sometimes they get things wrong. Trying to pretend that doesn't happen, and trying to run away from it, is not a useful occupation. In the situation that you described, it has led to a lot of wasted time when you could have been doing something else. I'm not going to pretend otherwise about that. I do not accept that it is impossible to do an effective investigation, but that has to be on the basis of highly skilled, invested in, case handlers who get support for development from their organisation.

As far as what Scott Morrish is saying, I'm in 100% agreement. If there was more talking amongst those who have responsibility for dealing with this on a system-wide basis then there would be a demystification of what's going on. Without laying it on with a trowel, you have played an important role in trying to get people to talk to each other as far as that's concerned. I'm all in favour of that. I think that's what our open meetings and our new strategy is about, trying to demystify and share our problems with other people so that we don't pretend that we're right about everything.

That also goes to my colleague from the Medical Defence League. I don't want to meet you in the Court of Appeal where we're spending thousands of pounds on legal representation which may not be in the interest of the patient. That is a waste of public money. If there was a more effective dialogue, and if

there was more mediation and early resolution, then it would be possible to reach resolutions which sensible people could accept.

Simon Bastow: Are there formal, institutional, things that can be done as well as, just, opportunities for dialogue?

Rob Behrens: Of course. I've been quoted as saying that there is no effective system of complaints handling in the NHS. You need to treat that with care. There is a system of complaints handling, it's done by good and honourable people, but it's not consistent. It doesn't replicate itself across the health service. It's different in different institutions. Therefore, it's not really a system in that respect.

We can't reform that on our own. If we sat around a table, as we're trying to do, with the bodies in jurisdiction, the regulators, there is an opportunity for us to come to a consensus about what constitutes an effective system of complaints handling, which is in my interest because I want bodies in jurisdiction to solve the problems before they come to us. It's a waste of people's time to have to go from one regulator to another. Of course, if we sat around a table and discussed these things, it is perfectly possible to make it better than it currently is.

Simon Bastow: The issue of fear… Sorry, do you want to say…

Liam Donaldson: I'll pick that up, but I was just going to… I know we're getting close to our deadline. I just wanted to say two things. The first one is that I've just finished, or almost finished, the fieldwork for a study we've done at the World Health Organisation, in-depth interviewing of 15 patients around the world… families around the world who've suffered serious harm. The report will come out sometime next year.

The most striking conclusion of all is that victims of harm encounter the same phenomena whichever healthcare system they're in. Cover-up, denial, rejection. In the care itself, not listening to a mother when a child is obviously dying. I make that point for one very simple reason, what I'm not saying is, "Don't worry about the NHS because it happens everywhere." I'm saying the opposite, I'm saying, "There is something so deep-seated about the adverse features of healthcare culture that it transcends the design of healthcare systems entirely."

My second point is a very brief story. One of the patients that I've worked most closely with, a woman called Margaret Murphy. A wonderful person, in Ireland, whose son, Kevin, died at the age of 21 through a catalogue of errors. Basically, where he had a life-threatening condition and it was missed. Features ranging from a missing post-it note to the failure to take test results. In the end, he died at the age of 21. She's been one of the greatest and most passionate and compassionate advocates.

I've heard her tell her story many times. I was talking to her recently. She told me something that she hadn't said before, in any presentation.

On the day that Kevin died, the family came back to collect his affects. They were sitting in the lobby of the hospital waiting for their transport. The junior doctor who had been caring for Kevin at the end when he actually died, which was the final stage of his illness which hadn't been diagnosed, saw them and came down and sat beside them to talk about Kevin. Before he sat down, he did one thing. He took off his white coat and he threw it on the floor before he sat down. That, to me, is such a powerful statement of what the right culture should be in healthcare. He took his white coat off, and he threw it down on the floor. "I am your equal, let's talk about this tragic loss together and how terrible it was."

It's the draining out of… I taught medical students for years, they come in young men and women off the street as it were. They're dripping with compassion. The education system, and the way that healthcare is delivered under the pressure it's delivered, it squeezes the compassion out of far too many of them. That's part of our problem.

Simon Bastow: Reasons to be optimistic?

Liam Donaldson: I've been too pessimistic. What I'm trying to do is to say that it's down to us, we've got to change things. I think we can but that energy, that passion, has got to be instilled, and that's down to leadership.

Simon Bastow: A lovely and poignant note to end on. Please join with me in thanking our two excellent, wonderful, speakers tonight. Sir Liam and Rob. (Applause)

--AUDIO ENDS--