Annex A - Press Statements:

1. The following statements have all be made by me or my predecessor, Julie Mellor. They have not all been made about this Inquiry, but they do have relevance to the terms of reference of this Inquiry.

2. Press release dated 27 September 2023 Ombudsman Rob Behrens comments on the University Hospitals Birmingham review into organisation culture | Parliamentary and Health Service Ombudsman (PHSO) on Hospitals Birmingham NHS Foundation Trust (UHB) review into culture:

> Rob Behrens: *"Patient safety must be a priority, but for that to happen, the Trust has to listen to its staff and patients, accept accountability, and learn from its mistakes. It has made a start, but there is much work to do to before we see real change and a shift in the culture of fear that has been instilled at University Hospitals Birmingham Trust. It is clear from this review that dedicated staff do not feel safe raising concerns in case there are repercussions. The people who work at the Trust are proud to deliver expert care to the patients they serve. They deserve to work in a safe environment, where they are treated fairly, feel valued and are confident that when they raise concerns, those concerns are addressed."*

3. Press release dated 30 August 2023 Ombudsman comments on Lucy Letby inquiry being given statutory status | Parliamentary and Health Service Ombudsman (PHSO) on Lucy Letby Inquiry statutory status:

> Rob Behrens: *'We welcome the Letby inquiry being given statutory status. It is only right that there is such an inquiry into how she was able to carry out such heinous crimes for two years*

before her employer raised concerns with the police. This is the only way the families can get to the truth of what happened. It's the very least they deserve.

"Having said that, we still need a thorough, independent review of NHS leadership, accountability and culture, and it needs cross-party support. The culture of fear and defensiveness within the NHS is not isolated to this case, it is a widespread problem which our Broken Trust report laid bare. These recent events mean our recommendations take on even more urgency.

"This is the moment to reset the culture of the NHS which can only happen if we fully explore the problems and potential solutions. This culture of fear and defensiveness needs to change and be replaced by one where patient and staff voices are heard."

4. Interview dated 29 August 2023 with BBC Newsnight on Norfolk and Suffolk Mental Health Trust and wider NHS culture.

Rob Behrens: *"I come across a culture in the health service time and time again where managers say to me, if you're critical about what we do, it will scare people off and that's not going to help us. Now I understand that, but I also know that at the heart of the health service is public trust. If people are not told the truth about what has happened, then their relationship with the health service will be in further decline than it already is.*

'We know that Trusts will do a great deal when they are in a difficult position to try to preserve their reputation, sometimes

at the avoidance of the facts. We have to get together to try and change the culture of the health service, so that people feel more confident about accepting criticism."

5. Interview dated 23 August 2023 with ITV about NHS whistleblowing in the context of the Lucy Letby case:

   Rob Behrens: *"Whistleblowers themselves do not believe they are safe to go public. Those that do are in for a long and very difficult road because the law on whistleblowing is too weak and too much in favour against the body who has blown the whistle.*

6. Press release dated 18 August 2023 Ombudsman Rob Behrens comments on Lucy Letby verdict | Parliamentary and Health Service Ombudsman (PHSO) on Lucy Letby verdict:

   Rob Behrens: *"We know that, in general, people work in the health service because they want to help and that when things go wrong it is not intentional. At the same time, and too often we see the commitment to public safety in the NHS undone by a defensive leadership culture across the NHS.*

   ....

   "Good leadership always listens, especially when it's about patient safety. Poor leadership makes it difficult for people to raise concerns when things go wrong, even though complaints are vital for patient safety and to stop mistakes being repeated.

   "We need to see significant improvements to culture and leadership across the NHS so that the voices of staff and patients can be heard, both with regard to everyday pressures

and mistakes and, very exceptionally, when there are warnings of real evil."

7. Press release dated 29 June 2023 NHS must make patient safety more than just a promise | Parliamentary and Health Service Ombudsman (PHSO) on Broken Trust patient safety report:

> Rob Behrens: *"Mistakes are inevitable. But whenever my office rules that a patient died in avoidable circumstances, it means that incident was not adequately investigated or acknowledged by the Trust.*
>
> *"Every time an NHS scandal hits the front pages, leaders promise never again. But the NHS seems unable to learn from its mistakes and we see the same repeated failings time and time again. Our report looks at the reasons for the continued failures to accept mistakes and take accountability for turning learning into action. We need to see significant improvements in culture and leadership. However, the NHS itself can only go so far in improving patient safety. One of the biggest threats to saving lives is a healthcare system at breaking point.*
>
> *"The Government says patient safety is a priority but, if it means this, the NHS must be given the workforce capacity it needs. We need to see concerted and sustained action from Government to support NHS leaders to prioritise the safety of patients. Patient safety must be at the very top of the agenda."*

8. Comments published by the Guardian dated 23 May 2023 NHS England mental health trusts record 26,000 sexual abuse incidents | NHS | The Guardian on mental health patients and sexual assaults within the NHS:

Rob Behrens: *"We know that not only do mental health patients often not feel safe when receiving care, but they are not told how to complain about their experiences. If people are not empowered to speak up about their concerns, problems of safety will continue, and the situation will not improve."*

9. Press release dated 31 March 2022 Ombudsman responds to findings of Ockenden report | Parliamentary and Health Service Ombudsman (PHSO) on Donna Ockenden report into serious failings in maternity care at Shrewsbury and Telford NHS Trust:

> Rob Behrens: *"These women and their families were let down by shocking levels of maternity care with devastating consequences. What exacerbates the catalogue of errors over many years is that the voices of victims and the families were never heard, and they were even blamed for the outcomes. That is disgraceful. This report should be a wakeup call for maternity care services and Trusts. I echo Donna Ockenden's view that maternity care should be properly funded; staff well trained; and, when things do go wrong, Trusts must listen to the people affected and learn from their mistakes. This further highlights the urgent need for PHSO to be given powers of own initiative by Parliament, which would enable us to look into systemic issues such as this, without having to receive a complaint about it first."*

10. Press release dated 27 February 2023 Urgent action needed to prevent eating disorder deaths | Parliamentary and Health Service Ombudsman (PHSO) on culture of the NHS in relation to eating disorders:

Rob Behrens: *"It is heart-breaking to see repeated mistakes and tragedies like this happening again and again. We need to see a complete culture change within the NHS, where there is a willingness to learn from mistakes.*

"The Government also needs to fulfil its promise to treat eating disorders as a key priority so we can see meaningful change in this area and make sure patients receive the quality of care they deserve."

11. Blogpost by Rob Behrens dated 13 October 2022 What an Ombudsman does and how we can help you | Parliamentary and Health Service Ombudsman (PHSO) on the role of an Ombudsman and NHS culture:

    Rob Behrens: *"Ultimately, when things go wrong, we want people to feel that their concerns are taken seriously and addressed, and that lessons are learned. That requires a culture of embracing complaints. Rather than a culture of blame or fear, we want to see Government departments and the health service."*

12. Blogpost by Rob Behrens dated 28 October 2021 Freedom To Speak Up: Changing culture in the NHS and beyond | Parliamentary and Health Service Ombudsman (PHSO) on Freedom to Speak Up Guardians and changing NHS culture:

    Rob Behrens: *"If there is a blame culture, people are not open about mistakes and the opportunity to learn and improve is lost. Indeed, negative consequences may cause performance to decline further.*

"Speaking up, on the other hand, is about learning and improving. A speaking-up culture is one where people are able to make suggestions, constructively criticise and be open about errors without fear of reprisal. Organisations with a strong speaking-up culture listen to employees and learn from failings so that services can improve. The real issue is not whether mistakes are made, but how we react to them when they are made."

13. Press release dated 19 March 2019 Response to the Care Quality Commission's Learning from deaths report | Parliamentary and Health Service Ombudsman (PHSO) on response to the Care Quality Commission's Learning from deaths report:

    Rob Behrens: *"'Time and time again we find NHS investigations into avoidable deaths inadequate, causing further suffering to families who have lost their loved ones. People shouldn't have to come to the Ombudsman to establish what has happened to their loved ones, as health services should be able to carry out high-quality investigations and learn from what went wrong. The CQC's Review shows some welcome signs of progress but the NHS must encourage a more open culture, where staff do not fear reprisals, to improve the quality of its investigations and learn from mistakes."*

14. Press release dated 19 December 2018 Failure of Care Quality Commission to make sure NHS employs 'fit and proper' directors | Parliamentary and Health Service Ombudsman (PHSO) on PHSO's Blowing the whistle report:

Rob Behrens: *"The public and NHS staff must have confidence that NHS leaders are fit and proper to do the job and that whistle-blowers will not be penalised for raising concerns.*

"We need fair, transparent and proportionate oversight that stops leaders who have committed serious misconduct from moving around the NHS and makes them accountable for their actions."

15. Press release dated 23 January 2018 Ombudsman comments on proposed Health Service Safety Investigations Bill | Parliamentary and Health Service Ombudsman (PHSO) on proposed Health Service Safety Investigations Bill:

    Rob Behrens: *"Our casework demonstrates all too often how defensiveness can inhibit NHS*

    Trusts from identifying tragic mistakes and learning from them. A key function of the Health Service Safety Investigation Branch (HSSIB) is to provide an impartial safe space for this learning to take place so it's vital that it is wholly independent from hospitals. If the government gets this right, HSSIB can make an important contribution to improving patient safety."

16. Press release dated 13 December 2016 Ombudsman comment on CQC review of NHS investigations into deaths | Parliamentary and Health Service Ombudsman (PHSO) on CQC review of NHS investigations into deaths:

    (Previous Parliamentary and Health Service Ombudsman) Julie Mellor: "Time and time again we find NHS investigations into deaths inadequate, causing further suffering to families

who have lost their loved ones. Robust and effective investigations can only happen if NHS staff are properly trained. This report is a golden opportunity for NHS leaders to learn from mistakes and encourage an open, honest working environment where NHS staff do not fear reprisals."

17. Press release dated 19 July 2016 Ombudsman calls for culture change in how NHS investigates avoidable deaths | Parliamentary and Health Service Ombudsman (PHSO) on culture change in how the NHS investigates avoidable deaths:

> *Julie Mellor: "We hope that this case acts as a wake-call up for NHS leaders to support a no blame culture in which leaders and staff in every NHS organisation feel confident to find out if and why something went wrong and to learn from it. The new Health Safety Investigation Branch (HSIB) is a step a in the right direction but will only investigate a small number of cases.*
>
> *"We want to see a national accredited training programme for people carrying out NHS investigations and for this to include clarity about independence and accountability."*

18. Press release dated 1 March 2016 People not given answers when they complain to NHS, latest ombudsman report reveals on PHSO's report into
lack of answers for NHS complaints:

> Julie Mellor: *"The NHS provides an excellent service for thousands of people every day, which is why when mistakes are made it is so important that they are dealt with well. "When people complain to public services, they deserve answers. If mistakes are made, an open and frank apology should be*

given and action should be taken to stop it from happening again.

"Unfortunately, we are seeing far too many cases where grieving families are not being given answers when they complaint to the NHS, forcing them to endure more anguish and distress."

19. Press release dated 7 January 2016 Ombudsman welcomes appointment of first National Guardian for the freedom to speak up within the NHS on the appointment of Dame Eileen Sills DBE as the first National Guardian for speaking up safely within the NHS:

    Julie Mellor: "Our casework shows that the NHS still has a long way to a go to create an open and transparent culture. Our recent report on the quality of NHS investigations into avoidable death and harm revealed that distraught families are being met with a wall a of silence when they seek answers as to why their loved one died or was harmed. This new role will help create the culture change the NHS so desperately needs. It is vital that staff are empowered to speak up SO that the NHS learns from mistakes."

20. Press release dated 8 December 2015 Devastated families left without answers as avoidable death and harm incidents aren't being investigated properly by hospitals across England on review into the quality of NHS complaints investigations where serious or avoidable harm has been alleged:

    Julie Mellor: *"Parents and families are being met with a wall a of silence from the NHS when they seek answers as to why their loved one died or was harmed. Our review found that NHS*

investigations into complaints about avoidable death and harm are simply not good enough. They are not consistent, reliable or transparent, which means that too many people are being forced to bring their complaint to us to get it resolved. We want the NHS to introduce an accredited training programme for staff carrying out these investigations as well as guidance on how they should be done, so the public can be confident that when someone is needlessly harmed it has been thoroughly investigated and answers provided, so that action can be taken to prevent the same mistakes from happening again."

21. Press release dated 22 September 2015 New report sheds light on top hospital complaints investigated by the Parliamentary and Health Service Ombudsman on PHSO's report on the top three reasons for hospital complaints:

    Julie Mellor: *"We know that there are many factors that influence the number of complaints hospitals receive, such as organisational size, demographics and whether they actively encourage feedback from patients. strongly believe that NHS leaders should welcome feedback from patients and recognise the opportunities that good complaint handling offers to improve the services they provide. We are publishing this data to help hospital trusts identify problems and take action to ensure trust in the healthcare system remains high."*

22. Press release dated 19 August 2015 Ombudsman's report shines a light on human cost of poor public service in the NHS in England and UK government departments | Parliamentary and Health Service Ombudsman (PHSO) on PHSO's report on human cost of poor public service in the NHS:

Julie Mellor: *"Often people complain to us because they don't want someone else to go through what they or their loved one went through. This report shows the types of unresolved complaints we receive and the human cost of that poor service and complaint handling. Many of the complaints that come to us should have been resolved by the organisation complained about. Complaints provide an opportunity for learning and improvements and should be embraced at all levels of the organisation from the Board to the frontline."*

23. Press release dated 11 February 2015 Ombudsman comments on Francis whistleblowing statement on Robert Francis whistleblowing statement:

> Julie Mellor: *"I welcome Sir Robert Francis' focus on 'just culture' which looks at whether the safety issue has been addressed rather than who is to blame. We are delighted the description we developed with patients of their expectations for raising concerns and complaints will be adapted to apply to NHS staff. This puts patients and whistleblowers at the heart of the way safety concerns are dealt with."*

24. Press release dated 20 October 2014 Statement on our systemic investigation into quality of NHS investigations of avoidable harm | Parliamentary and Health Service Ombudsman (PHSO)on PHO's systemic investigation into quality of NHS investigations of avoidable harm:

> Julie Mellor: *"When public services fail, it can have serious effects on us as individuals. We know that when people complain, they often want three simple things: an explanation*

of what went wrong, an apology and for the mistake not to be repeated

"We know in other industries like aviation and construction when things go wrong, they investigate to find the root cause, not to determine blame. They design and deliver services based on reducing or eliminating mistakes.

"Our casework indicates that there a is a wide variation in the quality of NHS investigations into serious cases such as complaints about potential avoidable harm. These include failure to explain fully what happened and why, inadequate involvement of the complainant and a lack of independent clinical input.

"That's why we will examine our casework, including more than 250 cases of potential avoidable deaths. We will analyse whether an investigation would have been appropriate but did not take place or when an investigation took place but was not a of a high enough standard.

"We will work with experts across health and other sectors to gather evidence of best practice and areas of improvements and will make recommendations for system wide change to the leadership and delivery of patient safety. We will publish our initial findings early next year."