This is really important. E 1GM

Staff are wrongly cleared of blame by NHS inquiries

Kat Lay Health Correspondent

NHS hospitals cleared their staff of blame in nearly three quarters of cases where patients died or were seriously harmed, despite failures that were later found by independent investigators.

The Parliamentary and Health Service Ombudsman said that families and patients were being left without answers by inadequate hospital investigations. The poor quality of the investigations also meant that changes to prevent the repetition of mistakes were being delayed.

Dame Julie Mellor, the ombudsman, said: "Parents and families are being met with a wall of silence from the NHS when they seek answers as to why their loved one died or was harmed.

"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."

The ombudsman called for an accredited training programme for staff carrying out investigations, as well as for new guidance. Her report said that hospitals used inconsistent methods, failed to gather sufficient evidence, and did not look at the evidence they did have closely enough.

A fifth of investigations missed crucial evidence such as medical records, statements, and interviews. In more than half of the investigations carried out by a clinician, the clinician chosen had been involved in the events.

In 73 per cent of cases where the ombudsman found clear failings, hospitals had claimed in their own investigations that no failings had been found.

The ombudsman judged 28 of the cases examined to be serious enough to require a serious incident investigation, but only eight had been classed as such by the NHS. The report highlighted the case of a baby girl who was left with brain damage by errors made during a blood transfusion. Her parents had to wait for three years to find out what had happened and the ombudsman found that the investigation had been carried out by a close colleague of the paediatrician in charge on the day the mistake was made.

Even when trusts uncovered failings in care, the lessons were not passed to frontline staff, the ombudsman found.