NHS did not learn from child's needless death

Chris Smyth, Health Editor

Patients are dying because NHS investigations into mistakes are incompetent, defensive and lack independence, a damning review has concluded.

After a bereaved family's five-year fight for answers over the death of their three-year-old son, the NHS ombudsman yesterday demanded a total overhaul of how the health service investigates harm to patients.

Investigations are often designed to avoid blame rather than find out what went wrong and why, the report says. Fatal mistakes can be repeated because hospitals, GPs and managers fail to accept the possibility that they have erred, and the NHS needs serious "soul-searching" to put it right, the ombudsman says.

The findings stem from the death of three-year-old Sam Morrish from sepsis in 2010. Hospital staff, GPs and out-of-hours services told Sam's parents that he had just been "unlucky" and that there was nothing they could have done differently.

Scott and Sue Morrish refused to accept that, forcing a first report by the ombudsman which confirmed that Sam's life should have been saved.

He was repeatedly sent home by GPs; call handlers failed to recognise danger signs; and when he finally got to hospital antibiotics were delayed for several hours because of a mix-up between staff.

Mr and Mrs Morrish said that this conclusion still did not get to the heart of the problem, which was why the original investigations into Sam's death failed to learn lessons that could save other children.

In a follow-up report Dame Julie Mellor, the ombudsman, found that Sam's GP, Torbay Hospital, NHS Direct and an out-of-hours service made no clear attempt to find out what they could have done differently.

Sam's case "like so many others, shows that organisations were not competent in the way they investigated this serious complaint and that this incompetence went unchallenged", Dame Julie warned.

She added: "Across the NHS a fear of blame pervades that prevents individuals and organisations being open to the possibility that their initial view of what happened might not be the right one, and means they are not asking questions about what happened and why."

Sam Morrish died after failures by his GP, call handlers and hospital staff

Dame Julie said that health services were therefore failing to learn how to prevent mistakes being repeated and insisted that the report must be "a wake-up call for NHS leaders" to change the way they investigate. She demanded a national programme to train NHS investigators, saying that it was wrong that staff can investigate their own mistakes or those of their colleagues or bosses.

Mr Morrish said that the report was "a huge step towards explaining how things go wrong at a local level". He said "there should be no question that can't be asked and none that can't be answered", insisting: "I hope that this report leads to rapid change in the culture of the NHS so that mistakes can be recognised, investigated and learnt from. Anything short of that isn't safe for patients and isn't fair to NHS staff."

Jeremy Hunt, the health secretary, is creating a health safety investigation branch, modelled on how airlines investigate plane crashes, which aims to allow staff to be honest about mistakes without fear of blame.

Mr Hunt urged NHS leaders to learn from the report, adding: "The tragic death of Sam Morrish shows why it is so important we listen to patients and families — no other family should have to go through what they have, and we are determined to build the safest healthcare system in the world."

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Analysis

Scott Morrish describes himself as someone who needs to ask questions (Chris Smyth writes). The problem was, his local NHS did not feel it needed to answer them. It was this lack of interest in the truth about the death of his son that turned a personal desire to understand into a five-year fight to ensure the NHS learns from its mistakes. Mr Morrish and his wife Sue could not understand how their happy, healthy boy was suddenly gone. But "shoulders were shrugged" and they were told to let it go.

The fight has taken up so much of his time that Mr Morrish, who runs a business with his wife, says: "If I had been in any other job I would have been fired years ago".

Mr Morrish hopes to get some of his life back, but says he will "keep an eye on" whether the changes urged today actually happen. It is a heavy responsibility for a grieving family to bear.