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NHS cover-up culture: civil litigation helps finds the truth

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Introduction: the problem

Investigating adverse clinical outcomes is vital for patient safety; it serves many functions including opportunity for learning and teaching, raising care standards, safety audit, professional accountability, and preparation for any potential compensation claim.

It ought to be embraced. Sadly, the reality is the opposite: an ostrich approach by the NHS - an institutional lack of openness and transparency. The health service cannot be trusted to investigate itself. Reputation is supreme, trumping patient safety, to sustain the delusion that the NHS is the envy of the world. It is more important than its patients.

Wes Streeting, the Health Secretary, called it “cultural rot” in the national press. The Parliamentary Ombudsman’s 2023 report “Broken Trust” listed NHS failings, including “failure to be honest” and “poor-quality investigations”. It is a matter of official record. Far from being a cause for concern, the culture of cover up has become normalised.

There are extensive local and national mechanisms for investigating adverse outcomes; their efficacy is inconsistent and unreliable. Duty of candour letters have largely become a box ticking exercise.

So how to investigate adverse clinical outcomes?

Civil litigation

Clinical negligence litigation provides a partial solution: but even a partial solution is better than none. It is concerned with breach of duty causing injury. However, it provides independent, rigorous, judicially regulated investigation according to accepted medical professional norms. The injured patient initiates the action, is a party in an adversarial process and has an active role in proposing the issues, framing the questions: the evidence, the witnesses, the scope, and the direction of the claim.

Clinical negligence litigation is a commercial activity driven by claimant lawyers. Like all businesses, it is about money and how it moves. Access to justice is funded largely by conditional fees, free at the point of need, and available to all. It is a tribute to the enterprise of claimant lawyers, and a triumph of privatisation. Legal aid funds just 0.5 per cent of claims against the NHS.

There are many millions of healthcare encounters, resulting in an unknown but likely significant proportion of adverse outcomes.

Claims must represent a minute proportion of clinical encounters. According to NHS Resolution Annual report and accounts 2023/24, last year there were over 13,000 cases against the health service. Claimant sources estimate roughly 300,000 inquiries.

Damages were paid in about 7,000 cases. Claimant costs are usually only paid in successful claims, which means that fees generated by roughly 7,000 successful cases funded the assessment of 300,000 inquiries. This represents a free clinical scrutiny service for the taxpayer.

Trials are expensive; last year there were 29. It demonstrates the efficiency of the litigation process. But while litigation is efficient, there is a weakness that originates in its funding.

There is a striking asymmetry in how lawyers are paid. Claimant funding is privatised, mostly conducted on a no win, no fee basis - it is payment by result that compels competence and economic prudence. There is also the marketing cost of claims acquisition.

Defendant lawyers are state funded. They are paid regardless of the outcome. It sustains reward for failure, and provides perverse incentive for “deny, delay, defend” behaviour. There are no claim acquisition costs.

Expert witnesses are rightly paid regardless of outcome, and regardless of which party they act for.

Clinical negligence cost the health service more than £2.8 billion last year; £2.1 billion was damages payment to claimants. But is this a price worth paying?

Alternatives to litigation

There is widespread concern that the negligence litigation system is economically unsustainable, prompting proposed alternatives to fault-based litigation. The past 50 years have seen periodic calls for a no-fault compensation. All have failed. It does not accord with political or economic reality. Any no-fault system will lower the threshold for claims, thereby increasing the number, but retain the requirement to prove causation. What machinery will manage a no-fault system?

There have been calls for increased use of mediation to resolve clinical negligence disputes. However, it is a non-evaluative consensual process. It is difficult to see its role in investigating adverse clinical outcomes.

The NHS Redress Act 2006 is enabling legislation. It proposed a voluntary alternative to litigation but retaining fault-based liability. It envisaged an integrated remedy based on qualifying liability in tort that would provide a redress package including an offer of compensation, explanation, apology, a report of action to prevent similar occurrences, and appropriate treatment. Legal rights would remain intact but would be waived if an offer was accepted. The statute proposed the NHS investigating itself and effectively adjudicating on its own liability: a clear conflict of interest, lacking the independence, authority, and deterministic finality of a judicial process. There are no plans to implement the Act - it rightly belongs in the dustbin of history.

Coroner's inquest

The need for a coroner's inquest is imposed by law and arises in certain categories of death. In the clinical context it concerned with unnatural death or where the cause of death is unknown. The central question for the inquest is: how did the patient die? The inquest is fact-finding. It is not a trial to determine legal liability; there are no parties. The coroner decides the evidence, the witnesses, and the scope of the investigation. Bereaved relatives have little say. Challenging coronial decisions is costly and cumbersome. Public dissatisfaction seems widespread and largely unaddressed - amply demonstrated by the written evidence submitted to the recent inquiry on coroners by the influential House of Commons Justice Committee.

The NHS spends large amounts on legal representation at inquests. However, findings of fact are not binding. Legal rights are neither asserted nor defended, so the purpose must be to protect reputation, a fight over the facts: better that an inquest conclusion is unclear than damaging to NHS reputation.

Too often there are no independent clinical expert witnesses. Instead, the court relies on the testimony of doctors acting both as witnesses of fact and as expert witnesses — a potential conflict of interest. Where is the essential rigorous independent clinical scrutiny?

Too often an inquest involving patient death is about the NHS investigating itself, but with the cloak of respectability of a judicial process. The court should not do the NHS's washing.

The Ministry of Justice has proclaimed that the bereaved should be “at the heart” of the inquest process. Fine words: too often the opposite is true.

Criminal litigation

This can involve gross negligence manslaughter and murder. The state is the prosecuting and investigating agency. Such cases are high profile but very rare. Clinical details are examined in minute detail; the standard of proof is high. Criminal liability is mentioned for completeness; it is unlikely to provide any useful remedy for most cases of adverse clinical outcome.

Conclusion

Instead of seeking alternatives to fault-based liability or litigation more effort should be applied to making the litigation work better. This likely involves reviewing the economic drivers.

Justice is open, and subject to public scrutiny. Expert witnesses perform a vital role in the administration of justice.

So long as the health service places its reputation above patients, there is a need for civil litigation.

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