Patient Recall Findings within the Lower Limb Lengthening and Reconstruction Service, part of the Orthopaedic Surgery Department

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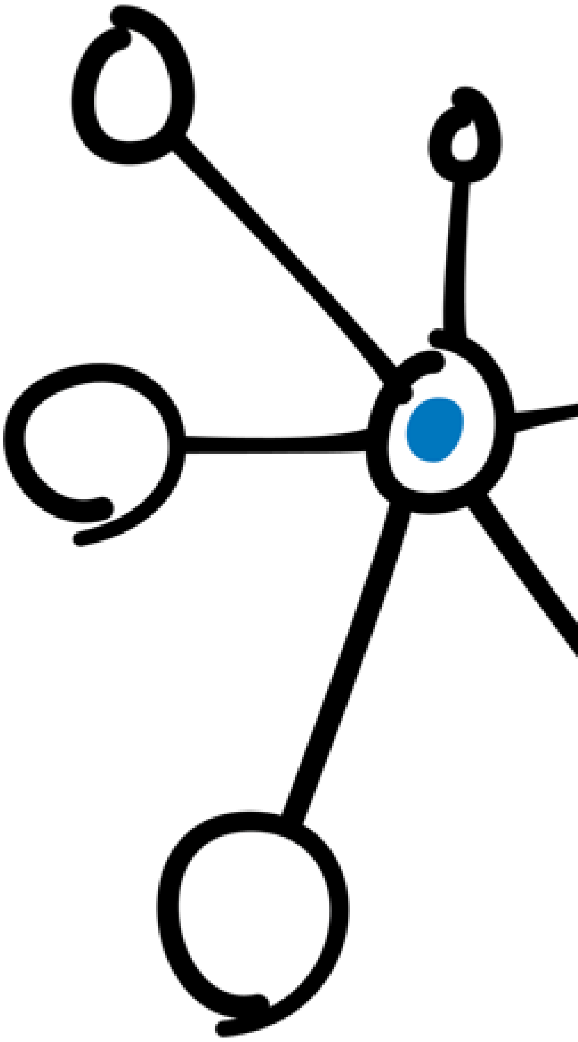

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Foreword

On behalf of the Trust Board, we want to first offer our sincerest apologies to all our patients and their families who have been affected by the care provided by an Orthopaedic Surgeon at our hospital between 2017 and 2022.

We have heard extensively from patients and their families about the impact this care has had on them, and we know that we have broken the trust that so many families place in us. We have also heard of the guilt that many families are carrying that they did not spot that something was wrong, or that they feel they should have spoken up. The harm their children have come to happened in our hospital and is no one's fault but ours.

This report sets out what we found in our review of patient care in full. It is important that we are open and honest about what has happened, what we have learnt and what we are doing as a consequence.

The independent patient review process was extensive, and we recognise how difficult this may have been for patients and families. We are very grateful to the families who took their time to give us feedback during the review, which helped us change and improve elements of the process.

Each review was shared in its entirety with patients and their family. We know that these reviews could never capture the totality of their experiences and may have felt limited and blunt. We are sorry for the distress and worry that has been caused by both the review process and the reports themselves.

We have a duty to ensure all our services are safe and to learn from when things go wrong to make all our care better and safer. As a result of this review, the Orthopaedic Team has put in place a range of measures to improve the quality of care provided. This has particularly focused on how a patient's care plan is decided from the outset to ensure that the care to be delivered is the best course of action for that patient.

We have identified learnings that we need to take across the hospital. This has led to a particular focus on standardising the way patient care is discussed, agreed and documented. We have also invested in support for our clinical leaders, including the introduction of a new, speciality lead training programme.

We know that the culture of teams and services plays a key part in how concerns are raised promptly. We want to acknowledge and thank our staff who spoke up with their concerns which led to us commissioning the Royal College of Surgeons of England (RCS) Review. Raising concerns about a colleague takes courage and we value the trust that our staff placed in us by doing so. But we know that there is more we can do - and are doing - across the hospital to ensure that our staff, patients and families feel able to do this at the earliest opportunity, and that concerns are acted on. We hope that the changes we have made and continue to make as a result of their experience will help prevent future patients and families going through what happened to them.

We would like to thank the Orthopaedic Team for the care they have continued to provide to patients through this process, and for the changes they have made to the way they work to make their service better and safer.

We would also like to thank the independent experts for their support in this process and for their commitment to completing their reviews impartially.

To our patients and families, we would like to again offer profound apologies. We know that nothing can make up for the experiences that you have had, nor can we fully understand the impact this has had on your lives. We have an unwavering commitment to learn and change so we are able to provide the safe, high-quality care that all our families expect of us and deserve.

Ellen Schroder, Chair

Matthew Shaw, Chief Executive

Executive Summary

This summary explains why we carried out a major review of patients treated by an Orthopaedic Surgeon, what was found, and what the hospital is doing to improve care.

Why the Review Happened

Following concerns raised about Mr Yaser Jabbar's clinical practice in June 2022, the Trust commissioned the Royal College of Surgeons (RCS) to review both his work and the broader Orthopaedic Service. The RCS recommended a detailed review of approximately 200 of Mr Jabbar's patients. To ensure thoroughness, the Trust expanded this to include all patients he had seen, initiating a full recall of 721 individuals in February 2024.

How the Review Was Completed

A group of senior children's Orthopaedic Surgeons from outside GOSH independently assessed each patient's records, including clinic notes, scans and operation details. Where information was missing or unclear, they requested further documentation or arranged to see the patient in person. Families were kept updated and, when reviews were complete these were shared. For those who had a grading of harm they could choose how they wanted to receive the outcome: by letter, phone, video call or in person.

What the Review Found

Most children were not harmed by the care they received. However, the independent experts found that 98 patients (12.4%) experienced some level of harm, and 94 of these cases were linked to specifically the care provided by Mr Jabbar. Harm gradings ranged from mild, such as an unnecessary general anaesthetic, to severe gradings for situations like delayed diagnosis of complications or surgery that did not achieve the intended outcome.

In some cases, the patient records were incomplete, making it impossible to reach a clear conclusion. A very small number of children came to harm for reasons not related to Mr Jabbar, such as administrative delays or issues involving other clinicians.

What was Wrong with the Care

Across the seven areas of care reviewed by the independent experts, they found inconsistencies in the approach taken across all areas. There were higher numbers of patients graded as coming to harm who were part of a surgical pathway. This didn't necessarily mean that all those who came to harm, did so as a result of the surgery itself, but could include any part of their clinical pathway.

In addition, the review found several recurring problems. Some patient records were unclear or incomplete. Consent discussions were not always fully recorded. In some cases, assessments were brief or key information was missing. Decisions about surgery were not always well documented, and alternative treatment options were sometimes not explained clearly. Occasionally, complications were not recognised or acted on quickly enough. These issues affected families' understanding, confidence and, in some cases, their child's recovery.

How Families Felt

Many families told us they experienced distress, worry and frustration during both their child's treatment and during the review.

When reflecting on how their child was cared for at the time, some felt their concerns had been dismissed, or that they did not have enough information to make decisions. Parents also spoke about feeling guilty, even though none of this was their fault.

Feedback from families helped improve the review process itself including the introduction of a dedicated Complex Case Manager to support families and improving how results were shared.

What GOSH has Done to Improve Care

We have taken a range of steps to ensure children receive safer, more consistent care. Within the Orthopaedic Service this includes improving how new patients are assessed and followed up and introducing clearer processes for planning and reviewing all cases. All patients are now discussed in multi-disciplinary team meetings both before and after surgery. Particularly complex cases are also discussed with clinical colleagues from the Royal National Orthopaedic Hospital.

Changes are also being made across the whole hospital to strengthen patient safety. These include standardising the way patients are reviewed before and after treatment and how discussions are held when there is an unexpected outcome. We are also ensuring all our services have ways they can measure outcomes and compare themselves with outcomes from other centres. Effective teamwork is being fostered through the development of a leadership programme for the lead of every clinical specialty. We are also working to ensure families are supported in raising concerns.

Support for Families

GOSH is deeply sorry for what the children and their families affected by this review have experienced and the lasting impact this may have. Support continues to be available, including psychological help, the Patient Advice and Liaison Service (PALS), and external organisations such as Action against Medical Accidents (AvMA).

Chapter 1: Introduction and Context

In this chapter we explain what we have intended this report to be, why the review was commissioned, and information about the surgeon and the Orthopaedic Service.

What This Report Is

This report is first and foremost for patients and families who have been impacted by the review into the care provided by Mr Jabbar. Information has been included which we believe will be of most use and relevance to them, and we have tried to set it out in a way that provides clarity on what has been a lengthy and complex process.

We appreciate that this report contains lots of information, we will ensure that versions in other languages and formats will be available. We have also provided a brief introduction to the start of each chapter to help explain what will be contained within the chapter.

This report gives the final numbers of patients reviewed, provides the figures in relation to the patients who have been deemed to have to come to harm, and summarises the themes identified in relation to the areas of care assessed.

Senior members of the hospital offered to meet with any patient and/or their family impacted by this review and held more than 100 conversations of this nature. This report contains feedback from patients and their families that was shared during these conversations and what we can learn from them.

We have also highlighted where changes were made to the recall process or the support provided throughout the review as a result of the feedback received from our patients and their families. We can assure all patients and families that there are no identifiable comments included within this report.

We have sought to learn from the process and findings of the patient recall and the review of the Orthopaedic Service and identify those learnings that could be applied more broadly across the hospital. The wider learnings and actions taken are described in Chapter 4.

We are committed to sharing our findings, what we have learnt, and how it can be applied broadly to improve care for all.

Where terminology may be difficult to understand, we have provided a glossary of the terms used in the report which can be found in Chapter 6.

Patient Recall

Following concerns raised by a colleague we asked the Royal College of Surgeons (RCS) to review the practice of Mr Jabbar. The RCS recommended that we review approximately 200 of Mr Jabbar’s patients. We extended our review to all of the patients seen by Mr Jabbar to ensure a thorough assessment of whether any harm could have occurred to any of his patients at any stage of their care journey.

In February 2024 we announced the patient recall, initially for 721 patients, and we committed to sharing the findings with patients and their families once we had completed the process. All patient reviews were completed by October 2025.

The RCS were also asked to review the practice of another Orthopaedic Surgeon who volunteered their cases, and the wider Orthopaedic Service – more information on all elements of their review, findings, and actions can be found in Chapter 4. Of note, the practice of the other Orthopaedic Surgeon reviewed was found to be of a good standard.

The Surgeon - Mr Jabbar

Background

Mr Jabbar, a Consultant Orthopaedic Surgeon, started working as a Consultant in 2014. He was British and trained at a medical school in the United Kingdom.

He joined GOSH in 2017 following a competitive recruitment process, with no concerns raised regarding his clinical practice or behaviour. Prior to joining GOSH, Mr Jabbar worked at a London Teaching Hospital as a Consultant Surgeon in Paediatric Orthopaedics and Limb Reconstruction.

As one of the Consultant Orthopaedic Surgeons within the Limb Lengthening and Reconstruction (LLR) Service, Mr Jabbar's scope of practice included treating patients with a range of orthopaedic conditions. Some of these treatments involved the use of circular frames, metal plates, bone grafts, implants, and castings as appropriate. In addition, Mr Jabbar worked with Interventional Radiology to treat children whose blood vessels did not form properly at birth (vascular anomalies).

Concerns into His Practice

Following concerns raised in June 2022, we asked the RCS to review Mr Jabbar's practice. We also initiated an investigation in line with the hospital's Maintaining Higher Professional Standards (MHPS) policy. Whilst this investigation was underway and following discussions with the General Medical Council (GMC), restrictions were placed on Mr Jabbar's clinical practice and additional support was provided by another experienced Surgeon. Mr Jabbar took an unpaid sabbatical in September 2022 and formally resigned from GOSH in June 2023. A full timeline can be found in Appendix A.

When concerns were raised in 2022, we looked back at Mr Jabbar's work since starting at GOSH in 2017. In that time, there had been seven complaints raised and one Serious Incident (SI). One complaint related to his communication style, another relating to the care provided and the remainder relating to delays for treatment due to him being absent from the hospital. None of these complaints, in insolation or combined, provided any broader concerns that needed additional oversight or investigation, above and beyond the responses provided to the individual families.

The Serious Incident in 2021 was thoroughly investigated, with a second opinion sought from an external Orthopaedic Consultant. Both the Trust's internal investigation and the external review, highlighted specific actions which needed to be addressed by Mr Jabbar in relation to the family and patient in question, but it did not identify any wider concerns which needed a broader investigation. This SI was closed through the Trust's governance processes and was ratified by NHS England; it did not trigger any further exploration of any possible issue with Mr Jabbar's practice.

We maintained contact with Mr Jabbar throughout the RCS review process and advised him at the request of the RCS that he should be restricted from undertaking all clinical work. We also shared this with the GMC as part of our regular updates with the regulator. On receipt of the RCS Service Report in October 2023, we shared it with Mr Jabbar in November 2023 and submitted a referral to the GMC for their review. Mr Jabbar voluntary relinquished his license to practice with the GMC in January 2024.

Orthopaedic Service

The Orthopaedic Service at GOSH consists of a range of clinical professionals, including Consultant Orthopaedic Surgeons, Resident Doctors, Nurses, Clinical Nurse Specialists, Physiotherapists, Occupational Therapists, Orthotists, Psychologists, and Play Specialists. These clinicians work in partnership with the Administration Teams, and work alongside several other specialist teams to deliver holistic care to patients and their families. Mr Jabbar worked in the Orthopaedic sub speciality of Limb Lengthening and Reconstruction (LLR).

The LLR is a highly specialist service within the wider Orthopaedics and Spinal Department at GOSH. It assesses and treats some of the most rare and complex conditions affecting the arms and/or legs, many of which have no established standard approaches either nationally or internationally. Because these conditions can be so complex, clinical practice often varies between individual specialists, and treatment plans must be tailored to each child's unique presentation. The surgery associated with these conditions carries complication rates between 35 and 85%.

Patients are usually referred from other paediatric centres but can be referred from other departments within GOSH. Therefore, it is common for the Orthopaedic Team to work in conjunction with other teams across the hospital. As GOSH does not have an Accident and Emergency Department, and we are not part of any trauma network, much of our work is conducted on an 'elective' basis. This means that most of the clinical work is planned and not performed on an emergency basis. Patients are seen in dedicated limb reconstruction outpatient clinics and complex cases are discussed at multi-disciplinary team (MDT) meetings. The Orthopaedic Service provides an on-call advice service to other hospitals nationally, where clinicians can phone for advice on rare and complex patients.

During 2024/25, a total of 80 operations were performed within the LLR Service, and 823 outpatient appointments took place.

Chapter 2: Patient Recall - Methodology

Here we provide an overview of how the patient recall was established, managed, and the level of oversight in place. We discuss how the numbers of patients were determined, and the definitions used to categorise the levels of harm.

Governance and Oversight

In April 2024 we stood up the Orthopaedic Service Improvement Programme Board (OSIP Board) to oversee the actions required from the RCS review and provide leadership to the work. This was chaired by the Chief Medical Officer (CMO), with representation from NHS England and other members of the Trust.

The OSIP Board met fortnightly and were presented with updates on the number of patient reviews completed, the levels of harm found, and any reparative actions necessary. The OSIP Board reported to the Executive Management Team, chaired by the Chief Executive, after each meeting and provided assurance reports to the Trust Board and the Quality, Safety and Experience Assurance Committee (QSEAC), a sub-committee of the Trust Board, for oversight.

Once the concerns were raised in June 2022, these were communicated with the Care Quality Commission (CQC) and NHS England - both of which have supported us through the recall process and decision making where required. On receipt of the report from the RCS in October 2023, we shared the report with the CQC and our Commissioners at both NHS England (London Region) and North Central London Integrated Care Board (NCL ICB) and have ensured that regular updates on progress have been shared with them.

Identifying Patients to be Reviewed

When the decision was made to review Mr Jabbar's patients, we determined that it was essential to include all patients who had clinical contact with him, rather than approximately 200 patients suggested by the RCS in their report. This approach was to ensure a thorough assessment of whether any harm could have occurred at any stage of a patient's care journey.

GOSH has an electronic patient record system (known as Epic) and this, along with historical data sources, were searched to identify patients with any reference to Mr Jabbar in their record. A total of 851 patients were found, and two Senior Clinicians reviewed all records to determine the level to which Mr Jabbar was involved in their care. At this point, 130 patients were discounted from the review process as there was no clear evidence, on the initial review, of clinical contact with Mr Jabbar or his team, leaving 721 patients to be reviewed.

We grouped the 721 patients into four categories according to clinical priority, to ensure the patients who we were most concerned about were reviewed first. These categories were:

- Category 1: Serious Incidents (SIs), complaints, amputations, significant concerns on initial review, concerns raised by healthcare professionals, plates/nails used in their surgery.
- Category 2: All external metalwork, other complications not discussed as part of the consent process, unclear treatment plan.

- Category 3: Complications discussed as part of the consent process.
- Category 4: All other patients.

In February 2024 we wrote to all patients whose care was to be reviewed to explain the review process to them. Following this, two patients who were not initially flagged for review contacted our Patient Advice Liaison Service (PALS) and confirmed that they had clinical contact with Mr Jabbar. These patients were immediately added to the review cohort, increasing the total to 723.

Working with Other Hospitals

Mr Jabbar worked both for the NHS and privately at other London hospitals, and therefore some of our patients have been treated by him both at GOSH and elsewhere. It was important for these patients that the entirety of their care – regardless of where they received it – was reviewed.

We identified 75 patients who were seen at GOSH and at least one other hospital, and it was agreed that the hospital where the most significant intervention occurred would lead the review into that patient's care. These hospitals are Chelsea and Westminster NHS Foundation Trust, Cromwell Hospital, The Portland Hospital, and St John and St Elizabeth Hospital. To support this work, we convened a small working group with key members of each of the relevant organisations, which also had representation from NHS England, NCL ICB and was co-chaired by the Medical Director from the CQC.

All hospitals where patients had been seen by Mr Jabbar worked together to share relevant medical records. From the 75 patients identified, 38 had their most significant intervention at GOSH and we manage their clinical review. The remaining 37 patients had their review managed by a different hospital. Of note, six of these 37 patients had already been reviewed by GOSH by the time this work was done and therefore feature in our reporting numbers, the other 31 patients are not included within our total numbers.

Adding Additional Patients to the Review

To ensure the patient recall process was as comprehensive as possible, in April 2025 we conducted a further review of the medical records of all the patients who had been initially excluded. This allowed us to better understand their interactions with Mr Jabbar and determine whether their care should be formally reviewed.

From the remaining 128 patient records, 97 were subsequently added to the review and two new categories were added. These were to be reviewed following completion of categories 1-4.

- Category 5a: Initially assessed as having no contact, but further searches found minimal involvement and limited records.
- Category 5b: Private patients with minimal involvement and no or very limited records held by GOSH.

For the remaining 31 patients, no evidence of clinical contact with Mr Jabbar was found. These patients were notified by letter of this decision and advised to contact PALS if they believed this was incorrect. To date, we have received no evidence to the contrary. For context, a Consultant's name can appear in records for reasons unrelated to direct care, such as triaging referrals, cancelled appointments, or clinic scheduling changes. A full summary of patient numbers can be found in Appendix B.

The Patient Recall Review Team

We initially recruited three independent, experienced Consultant Paediatric Orthopaedic Surgeons in the UK with specialist expertise in Limb Reconstruction to conduct the patient reviews. Of note, this is a highly specialised area of medicine with a limited number of experts nationwide.

The reviewers completed these patient reviews alongside their existing NHS duties, and we projected an 18-month timeline from May 2024, when the first reviews began. To ensure we could meet this timeline, between July and October 2024 we recruited an additional five reviewers to support the patient recall. We also approached some international experts, but due to differences in surgical technique and clinical approach, we chose to remain with those whose clinical practice aligned with UK standards.

Reviewers met collectively at monthly peer review meetings to discuss particularly complex cases and also took one out of every five cases they had reviewed to this meeting, to ensure a consistent approach to their assessments.

Reviewing Patient Care

The reviewers assessed the medical records and imaging available within our electronic patient record for each patient. If a reviewer could not complete an assessment based on available records but from the information available, and believed there could be a potential harm grading, they were able to invite the patient for a consultation and/or request additional imaging. In some cases, additional records were also requested from other centres when there was evidence a patient had been treated elsewhere.

For each patient, they completed a standardised report template which covered a number of areas. Experts used national guidelines to determine care, such as GMC “Good Clinical Practice” (published August 2023, updated December 2024). Where specific guidelines were not available during the reviewed timeline, the reviewers used their knowledge of acceptable practice to form an opinion. The areas reviewed were:

- Record keeping and documentation.
- Assessment, including history, examination, and diagnosis.
- Investigations and imaging.
- Consent process.
- Decision-making and case selection.
- Surgical skill and technique.
- Identification, management, and ownership of complications.

For each of the areas outlined above the reviewers were asked to determine whether the care provided was:

- Acceptable.
- Room for improvement.
- Unacceptable.
- Unable to determine.
- Not Applicable.

In addition, they were asked to comment on:

- General conclusions and summary of care.
- Evidence of physical harm.
- Recommendations for future care.

Recommendations in the Individual Patient Reviews and Closure of these

For each patient, the reviewers provided recommendations about whether any further care was required, including any additional interventions, or whether there was no further involvement needed.

For some patients, follow up appointments and/or referrals to other services were arranged. In addition, all patient reviews were added to their electronic patient record so their clinical team could see the review outcome and any recommendations. A patient's review status was marked as closed when all outstanding actions were completed.

Assessing and Defining Harm

According to NHS England's Policy guidance on recording patient safety events and levels of harm, a patient safety incident is defined as "something unexpected or unintended has happened, or failed to happen, that could have or did lead to patient harm". When such an event occurs, it is assessed to determine whether it resulted in harm and, if so, the level of harm, which can range from no harm to severe harm or death.

Harm may arise from a wide set of factors, such as mistakes in medication or clinical technique, as well as broader system issues like workload pressures, administrative failures, or delays in access to care.

NHS England emphasises that the process for determining harm must be objective and based on the best available information at the time, recognising that judgements are required when deciding whether an incident has occurred and what level of harm, if any, resulted from it. In the context of paediatric limb reconstruction, where staged or repeated surgery is often a necessary and planned part of treatment due to growth and development, further planned procedures are not considered harmful events.

As previously mentioned, Paediatric Orthopaedic Surgery, and particularly Limb Reconstruction a highly complex area of surgery, with many known complications some of which may be unavoidable. The challenge when assessing harm is being able to establish whether the complication was a result of poor care or was an expected complication for the type of care being provided.

We recognise that some patients and families may feel that the harm gradings do not fully capture the complexity or impact of their experiences, and we sincerely apologise for any distress this may have caused. However, it was essential that we followed a nationally recognised and standardised harm-assessment process to ensure consistency, fairness, and reliability in reporting.

To ensure that patients' and families' experiences were meaningfully represented, we have also included anonymised reflections that express the wider impact on their lives.

Levels of Harm

Physical and psychological harm were graded using NHS England's framework (August 2023, updated October 2024). The table below defines the levels in use within the framework. Additional information about the levels of harm can be found in Appendix C.

Examples taken from NHS Guidance of what the levels can mean:

- **Low / Mild Harm:** Unnecessary general anaesthetic and therefore additional recovery and observation time.
- **Moderate Harm:** Missed opportunity for timely intervention (e.g. a surgery was delayed significantly) which resulted in a more invasive surgical technique being required and extended the length of treatment.
- **Severe Harm:** Post-operative fracture due to poorly placed metal work. This would necessitate further surgery and a significantly extended recovery time.

For the patient recall, we introduced an additional grading of 'unable to determine.' This new grading was only assigned to those reviews where there was not enough information available to the reviewers to allow them to make an informed decision.

Psychological Harm

We recognise that other types of harm such as psychological harm are intertwined with any attribution of physical harm – especially in the cases of children, young people, and their families. Absence from school, or from not being able to play, can impact the wellbeing of our patients and those around them. This is a highly complex area to assess and quantify and can only be done meaningfully with a trained psychologist or other suitably trained professional.

We initially set out wanting to assess both physical and psychological harm, recognising that the two are very closely related. The reviewers were Orthopaedic Surgeons, not mental health professionals, and as such were not themselves in a position to assess or diagnose psychological harm. We recognise it is also very difficult to assess psychological harm purely from a review of medical notes and documentation.

We received feedback directly from patients and families that the assessment of psychological harm did not accurately reflect their experiences, and the subsequent gradings being applied were causing distress – we took the step to stop assessing for psychological harm. Therefore, from January 2025, psychological harm was graded as 'Unable to Determine' and only if records indicated there had been past Mental Health Team involvement was this referenced in their summary.

We recognise that whilst the approach for assessing psychological harm was well intentioned, it was limited and did not capture the full psychological impact as experienced by patients and families.

Other Factors Contributing to Harm

Patients rarely see one single clinician during their treatment journey, and this is especially true of patients with complex orthopaedic conditions. Whilst the review focused on care provided by Mr Jabbar, the reviewers looked at the complete treatment journey each patient received, which therefore often included other clinicians. In a small number of cases, they identified some concerns unrelated to Mr Jabbar's care, some of which resulted in harm.

This included substandard care by other Surgeons and poor administrative processes which resulted in some patients waiting unacceptably long times for appointments. In all these cases, these issues were investigated appropriately, discussions took place with the patients, families, and clinicians, and remedial plans were put in place if required.

Sharing Outcomes with Patients and Families

Once the review outcomes were received, these were discussed at a weekly meeting attended by a range of clinicians and included those involved in the recall workstream. These meetings ensured findings were addressed, care plans implemented where needed, and actions monitored.

No Harm Identified

When no harm was identified, unless the review findings required discussion, a cover letter was sent to the patient and their family with a copy of the full review report.

Patients were invited to contact PALS if they had any questions or wanted to discuss their review, and these were facilitated by the appropriate team.

Harm Identified

We recognised that for many patients and families receiving a review outcome that indicated harm had been found would be very distressing. Therefore, before sending the review report, we contacted all patients and families asking them how they would like to receive this. Patients could request the report in writing, over the phone, in a videocall, or at an in-person meeting. They could also request to receive the report prior to or following a discussion with us.

When harm was identified, we apologised and were open and transparent with our patients and their families about the grading, and what had contributed to this.

Supporting Families Through the Review Process

Our intention throughout the review process has always been to be open and honest with patients and families. We provided regular written updates to patients and families who were waiting for their review to take place to let them know how the review was progressing, and to share any other updates with them.

We recognised the review was not only a clinical process but that it carried significant emotional burden for families. Many parents described feelings of isolation, uncertainty, and distress during this period. The review highlighted the need for families to be heard, supported, and guided through complex conversations about their child’s care and the implications of the findings.

We ensured that support was available via phone and email, using translation services if required, providing families a direct route for queries and emotional support. Parents were supported in navigating difficult conversations with their children and were signposted to appropriate psychological services.

We offered informal discussions with either the Chief of Service and the Head of Patient Experience and Engagement, or with the Managing Director and Clinical Director from International and Private Care.

We held these conversations as it was important for patients and families to receive an apology from us and to be able to express their thoughts. A summary of the meeting was shared afterwards. For some patients and their families, we held additional meetings with them, so they were able to process and further understand the findings of their review and raise any additional queries they may have had.

For those patients and families who had specific Orthopaedic related questions, and were still a patient of GOSH, we arranged for them to meet with a senior Orthopaedic Consultant Surgeon who was able to address any questions they had in more detail and provide a greater level of clarity where needed.

In addition, we offered for patients and families to speak with other senior members of the hospital, who were not part of the review process, for them to share their experiences.

Consistent Communication

How and how often we communicate with families and patients in these situations needed careful consideration, with some wanting regular in-depth updates, whilst others wanted as little as possible. We tried to ensure that we respected those wishes where possible and provided quarterly update letters to patients awaiting their review to try to balance the needs of all patients and families.

Responding to Feedback

We are grateful to the patients and families who shared their feedback about the review process with us. This enabled us to make changes to certain processes and the way in which we communicated with them.

The changes made included no longer rating psychological harm and introducing a method by which patients and families who came to harm could choose how they received the outcome of their review. We also introduced the role of Complex Case Manager, which is described in more detail below.

Patients and families also shared with us some of the frustrations they had with the review process. These included the time taken for their reviews to be completed, and whether they could request a re-review of their notes or provide additional, anecdotal information to be considered by the independent experts.

Based on the notes and images that were available we chose to undertake a desk top review in order to ensure that we provided the same level of review to each patient and their family. We recognise that this approach may have had limitations, however it was driven by our commitment to be consistent and fair with all patients and families.

The provision of face-to-face clinic appointments for all families would have resulted in significant additional time being added to the recall timeline. In light of existing concerns about the timeline and our awareness that the review process itself was a source of some distress to the families involved, we determined this was not an acceptable approach. We also felt that it would be unfair if we began re-reviewing patients' part-way through the recall, and that this could have a negative impact on those whose reviews had previously been completed.

Recurring themes we heard from patients and families included a feeling of guilt, loss of trust in GOSH, and the level of emotional impact that the review was having on them. We are truly sorry that patients and families have felt this way and also for the additional burden this review has created.

We also acknowledge the concerns patients and families have expressed about being unsure how to raise issues with us, that they felt dismissed when they sought to raise concerns with Mr Jabbar, and the worry that they may be seen as a troublemaker which could adversely affect their child's care.

Complex Case Manager

In response to family feedback, in March 2025 we established a dedicated Complex Case Manager who was able to provide holistic support and advice to patients and families where required. This role was able to connect patients and families to psychological support.

This role was established in response to feedback from patients and families who described the review as “clunky” and explaining that they felt isolated with no clear route for raising concerns. This role provided a space for patients and families to express frustration, fears, and concerns about their wellbeing and their child or young person’s future. Feedback from parents said that they valued the reliability of promised call-backs, which helped begin to rebuild trust.

Once established, patients and families repeatedly expressed that this role was “crucial” and “vital,” with some stating they would not have pursued further information without it. We acknowledge that this role should have been in place from the start of the review and are grateful to those who highlighted this need.

Psychological Support

Psychological support was provided in response to feedback received from those impacted by the review. In addition to the Complex Case Manager, we acknowledge that this should have been available from the outset. Psychological input at an earlier stage, in hindsight, would have been beneficial, especially in relation to the decisions taken regarding the assessment of psychological harm.

A range of options for psychological support were available, depending on the need of patients and families. Some did not require a full psychological assessment, instead needing a space to speak and feel heard.

If patients or families required formal psychological support, the Clinical Psychology Team worked to prioritise those affected by the review. If they were still patients at GOSH, they received psychological support in the same way as other patients do. Patients and families told us that these interventions helped them feel comfortable continuing with their care at GOSH.

If they were no longer patients of GOSH, we made alternative arrangements to find a method of support which worked best for them. It was important for this range of options to be available, and patients and families told us this was important in differentiating what support they needed and enabled us to determine how best to provide it.

Chapter 3: Findings

This section details the findings of the patient recall programme. It is presented in two sections:

Section One: This sets out the number of patients who have come to harm, along with the level of harm that was caused.

Section Two: A summary of the areas of care arising from analysis of the findings of the independent experts.

Section One: Patient Harm Gradings

As discussed in Chapter 2, we have used the definitions of harm as defined by NHS England.

We understand that this report may be distressing to some of our patients and their families and for that we apologise. We also recognise that for many patients and families the grading of harm has felt unrepresentative of their experiences.

Where a rating of 'Unable to Determine' has been given this is because there was insufficient information available for the independent experts to be able to make an informed opinion on a potential grading of harm. Where the harm outcome was recorded as 'Unable to Determine' these have been listed as a separate finding below and have not been amalgamated into one of the other categories.

Total Harm Numbers

The independent experts carried out clinical case reviews for all 789 of Mr Jabbar's patients and found a total of 98 patients (12.4%) had come to harm.

Table 1: Total number of cases of harm found.

Harm Ratings	Total Patients (789)
No Harm	638
Mild Harm	20
Moderate Harm	40
Severe Harm	38
Unable to Determine	53
Percentage of Harm	**12.4%**

For four of the 98 patients who came to harm, although Mr Jabbar had clinical involvement with these patients, the independent experts found that this harm was not attributable to Mr Jabbar. For three of these patients, the harm caused was attributed to another Surgeon, who no longer works at GOSH. The other patient came to harm due to being lost to follow up, which means that they did not receive a timely clinical follow up.

The three patients whose harm was caused whilst under the care of another Surgeon had their care peer-reviewed by an external Consultant Orthopaedic Surgeon and then shared with the Surgeon directly. In addition, the concerns were discussed with the patients and families involved and with the GMC. The GMC advised that the cases did not meet the threshold for referral and advised that local support was required, which was provided by GOSH and their current employer.

Total Harm Numbers directly attributable to Mr Jabbar

The patient reviews found 94 (11.9%) patients had come to harm that was attributable to Mr Jabbar. Of these 94 patient cases, there were six patients where the harm was not attributed to solely Mr Jabbar, and there were additional aspects of their care which contributed to the overall harm rating applied. This included missed opportunities for on-going screening through treatment and lack of communication between services to address radiological findings for example.

Table 2: Total number of cases of harm found, attributable to Mr Jabbar

Harm Ratings	**Total Patients (789)**
No Harm	642
Mild Harm	19
Moderate Harm	39
Severe Harm	36
Unable to Determine	53
Percentage of Harm	**11.9%**

Harm Ratings - Surgical and Non-Surgical Intervention

Out of the 789 patients, 42.2% (333) were part of a surgical pathway. The table below shows the levels of harm identified across those who were part of a surgical pathway, compared to those who were not part of a surgical pathway.

Although these harm levels are presented by non-surgical and surgical patients, the harm may not have been attributed by the surgery itself. The harm could be a result of decision-making, lack of timely intervention, ineffective identification, and management of complications. We highlight some of the themes from each of the areas of care graded later in this chapter.

Table 3: Harm found in surgical and non-surgical patients attributed to Mr Jabbar

	Surgical	**Non-Surgical**
Number of Patients	333	456
No Harm	235	407
Mild Harm	18	1
Moderate Harm	38	1
Severe Harm	35	1
Unable to Determine Harm	7	46
Percentage of Harm	**27.3%**	**0.7%**

Section Two: Summary of Areas of Care

As part of their review process, we asked the independent experts to assess the care provided against seven key areas of patient care:

- General conclusions and summary of care.
- Record keeping and documentation.
- Assessment, including history, examination, and diagnosis.
- Investigations and imaging.
- Consent process.
- Decision-making and case selection.
- Surgical skill and technique.
- Identification, management and ownership of complications.

Each area of care was graded as either not applicable, unable to determine (if notes did not contain the information), acceptable, room for improvement, or unacceptable.

There were 371 patients (47%) whose care across all seven areas was graded as either acceptable or non-applicable, and for these patients there was no harm identified. We know from the data, that the attribution of harm was the lowest in those patients where decision-making and case selection, along with assessment, including history taking, examination, and diagnosis were both graded as acceptable.

As the number of areas of care rated as unacceptable, or room for improvement increased, the percentage of harm increased. All the areas of care are heavily interlinked, and it is therefore not possible to identify a particular cause or area of care which resulted in harm. However, the data analysis does highlight which areas, when marked as unacceptable or requires improvement, resulted in a higher number of patients coming to harm.

When looking at the group of patients who were part of a surgical pathway (333 patients), two areas of care, surgical skill and technique, and the identification, management and ownership of complications had a high number rated as unacceptable. These areas were rated unacceptable in 17.7% (n = 59) and 15.6% (n = 52) of patients respectively. In the remaining five areas of care, the numbers that were deemed unacceptable were much lower at between 6.1 and 9.3%.

Analysis of the independent expert case reports into Mr Jabbar's practice identified that Mr Jabbar was highly inconsistent in his approach to clinical care with recurrent deficiencies in documentation, assessment, and surgical decision-making. The reports have been analysed, and the following themes have been identified. We would like to assure you that these do not allow for the identification of any patient or family.

A summary of the findings of the different areas of care is detailed below. These document:

- An explanation of standard practice expected in the UK.
- Where Mr Jabbar's practice was assessed by the independent experts as meeting this standard.
- Where Mr Jabbar's practice was assessed by the independent experts as not meeting this standard.
- Implications for patients including, where available, feedback from patients and families.

There is inevitable overlap in the themes described in these categories. Concerns related to record keeping and documentation are reflected across all areas of care summarised below.

Consent

What is standard practice in the UK?

Children and young people should be involved in decisions about their care as much as they can, and their opinions should be respected. Consent must be real and valid. This means it should be given freely by someone who has the right and ability to decide. For children and young people, clinicians need to check if they are mature enough to understand and agree to the treatment themselves. If the child or young people cannot do this, consent must come from a parent or someone with legal authority, and doctors must always act in the patient's best interests.

Information should be clear, accurate, and explained in a way the child and young person can understand. Clinicians should make sure both the patient and their parents or families have enough time and support to make a decision, and they should check that everyone understands before moving forward. If the treatment plan changes or new options are suggested, consent must be reviewed and recorded at that time. Records should show what was discussed, including risks, benefits, alternatives, and if an advocate or interpreter was involved.

What were the findings of the review in relation to consent processes undertaken by Mr Jabbar?

Standard practice: The reviewers found satisfactory documentation of risks and benefits in many cases. This included MDT involvement in assessing proposed clinical treatment. Clear communication with patients and families of procedural plans was evident, involving interpreters where necessary. In many cases, opportunities for patients and families to reflect was evident from the medical records. Interventional radiology and combined procedure consents were generally well-detailed.

Sub-standard practice: Key issues were highlighted, such as missing, incomplete, or illegible consent forms, overuse of generic language, and insufficient documentation of alternative treatment options. There were instances where the procedure undertaken differed from what was originally consented to, with no proper record for the rationale for changes. A lack of documented consent around material risks, possible complications and alternative treatments was identified. Further risks were presented by administrative inconsistencies, such as altered dates and conflicting records, while limited Consultant oversight and inadequate recording of capacity and parent authority in complex cases highlighted the need for improved governance and record-keeping.

What are the implications for patients?

When consent forms are missing, incomplete, or hard to read, there is no reliable record of what was agreed. This undermines informed consent and can lead to children and young people having procedures they or their parents did not fully understand or approve. Using vague, generic wording and failing to note other treatment options means families may miss the chance to make choices that suit their child or young person's needs.

Errors like altered dates, conflicting records, and poor documentation of important risks weaken trust in the consent process.

Of those patients treated by Mr Jabbar, the independent experts identified that some patients were subject to inadequate risk counselling.

Many families said they were not given clear explanations about treatment options, risks, or why certain decisions were made. They were often confused about the purpose of procedures, expected results, and alternatives. Several families reported raising concerns directly with Mr Jabbar, but they felt these were usually dismissed.

History Taking, Examination, Diagnosis and Investigation

What is standard practice in the UK?

When taking a patient's medical history, it should be detailed and suited to their age and stage of development. This means looking beyond symptoms to include psychological, social, cultural, and family factors. Doctors should listen to the child or young person's views and concerns and avoid making assumptions about what matters to them. They should also consider any safeguarding issues or signs that the child or young person may be vulnerable.

Any tests or investigations should only be carried out if there is evidence to support them, they have been explained clearly, and the associated risks are discussed. Doctors should make sure tests do not conflict with other treatments and that results are shared quickly and accurately.

A diagnosis should come from a full assessment of the child or young person's condition, combining clinical findings, test results, and the child or young person's personal circumstances. Doctors should be open about what they know and what they are unsure of and help families make informed decisions about next steps. If a condition is complex or rare, the child or young person should be referred to a specialist without delay.

Records must be clear, accurate, and up to date. They should document the history, examination findings, test results, reasoning behind the diagnosis, and what was discussed with the child or young person and their family.

What were the findings of the review in relation to Mr Jabbar's clinical practice (History taking, examination, diagnosis and investigation)?

Standard practice: Many cases featured a thorough record of the patient history, examination, and diagnosis, supported by appropriate imaging and MDT involvement, which enabled accurate identification of key conditions and effective follow-up. Holistic approaches were evident in some cases, with psychosocial factors and allied health professional input helping to provide a comprehensive clinical picture, and remote consultations were sometimes used to maintain care continuity during the pandemic.

Some patients had thorough or adequate MDT documentation in place, with structured operative and inpatient notes with the patient's history, examination, investigations, and plans clearly documented. In some cases, there was acceptable clinic documentation to allow the reviewer to understand the decisions made. The information provided by the Allied Health Professionals (including Physiotherapy Teams and Orthotists) was detailed and well-constructed.

In many cases, the records showed appropriate selection and use of imaging modalities, such as X-rays, CT, MRI, and ultrasound, tailored to the clinical scenario and pathology, as well as the incorporation of pre and postoperative imaging. Imaging decisions were frequently supported by MDT input, with age-appropriate considerations and efforts to minimise radiation exposure in paediatric patients.

Sub-standard practice: Some records were brief or incomplete, and lacked essential details such as deformity measurements and neurovascular status, while preoperative planning and imaging reviews were sometimes missing. Consultation and involvement of additional specialists or specialty clinics was lacking in complex cases. There were instances of limited Consultant oversight, and insufficient documentation of planned corrections.

A lack of notes, or absence of essential details were consistently identified as a concern - this included operating notes, consent forms, planning notes, radiological and clinical measurements, risk benefit discussions, and rationale for deviations from agreed plans.

Concerns identified the absence of essential imaging before major procedures, and limited saving of intraoperative imaging. There was also a lack of documented clinical reviews of imaging in relation to deformity planning and measurements. Issues were identified with reliance on outdated images, poor record-keeping and interpretation, limited use of functional (weightbearing) or comparative views, which hindered diagnostic accuracy and safe clinical decision-making.

What are the implications for patients?

If a patient’s medical history is not taken properly or adapted to their age, important details can be missed. Factors such as emotional wellbeing, family circumstances, and social factors often affect health, and ignoring them can lead to wrong or incomplete diagnoses. This means the patient might get treatment that is not right for them.

A diagnosis should come from a full picture of the patient’s health, but when records are unclear or incomplete, it is hard to show why decisions were made or confirm they are in the patient’s best interests.

Of those patients treated by Mr Jabbar, where harm was identified, patients were subject to:

- Instances where surgery proceeded without documented comprehensive assessment, imaging review, or quantification of deformity.
- Wrong diagnoses and treatment decisions were sometimes made by looking only at scan or X-ray results, without properly considering how the patient actually felt or how their condition affected their daily life and abilities.
- Not properly comparing the images taken during surgery with the plan made before the operation and what the operation was meant to achieve.
- Poor recording of neurovascular assessments.

Case Selection, Decision-Making and Surgical Skill and Technique

What is standard practice in the UK?

Before recommending surgery, doctors must make sure it is truly needed and, in the patient’s best interests. This decision should come from a full assessment of the child or young person’s condition, needs, and circumstances, based on their medical history, examination, and test results. It should follow recognised guidelines and evidence and consider how effective the treatment is likely to be. Alternatives to surgery, including less invasive options, should always be discussed openly with the child or young person and their parents or families.

If surgery is recommended, the reasons must be clear and written down, including the expected benefits, possible risks, and any uncertainties. Decisions about complex or high-risk cases should involve input from different specialists and oversight from a senior consultant. Records should be kept up to date and show how decisions were made, so the process is transparent and can be reviewed if needed.

Doctors should never assume what matters most to the child, young person or family - they should involve them in every step of decision-making. If there are disagreements, these should be handled sensitively and in line with professional guidance. Above all, decisions must put safety first, be fair, and ensure continuity of care, while meeting professional and legal standards.

Doctors should only do work they are trained and competent to do, and they must keep their knowledge and skills up to date. They should provide care to a high standard, using proven and appropriate techniques for the child or young person's needs. If they choose a different approach from the usual method, they must have a good reason for it and record that reason clearly, with proper oversight. Throughout, the focus should be on keeping the child or young person safe, and ensuring care is consistent. Records must be accurate and easy to read, and all actions must follow legal and professional rules.

What were the findings of the review in relation to Mr Jabbar's clinical practice (case selection, decision-making, and surgical skill and technique)?

Standard practice: Decision-making and case selection demonstrated several strengths, including the use of appropriate conservative management, staged observation, and MDT input for complex deformities, as well as shared decision-making that acknowledged family preferences and functional goals. There was evidence of reasoned selection of surgical techniques aligned to patient needs, timely acceptance of non-intervention for stable conditions, appropriate referrals, and integration of psychological readiness and rehabilitation planning.

The review of surgical skill and technique revealed numerous strengths, including the frequent use of established procedures and constructs, thorough operation notes, and effective intraoperative imaging, which collectively contributed to successful outcomes in many cases. There were also examples of complex cases benefiting from dual Consultant involvement and teamwork, and technically sound limb reconstruction procedures.

Sub-standard practice: Inconsistent planning, undocumented day-of-surgery changes, insufficient MDT discussion and Consultant oversight in high-risk cases, and a tendency to prioritise radiographic findings over clinical symptoms.

Additional concerns related to limited documentation for complex decision making, with an unjustified preference for certain surgical techniques including unconventional or unrecognised procedures, or the omission of documented discussion of established treatment options.

There were instances of premature removal of fixation devices, the combination of procedures without clear rationale, inadequate counselling on fracture risk, and an over-reliance on junior staff.

There were some serious problems found, including poor planning before surgery, not making the area stable enough, unclear or incomplete notes, and putting implants in the wrong place. Other issues were making cuts in the bone at the wrong level or using the wrong method, making decisions that didn't match what was seen in the scans during surgery, problems with how frames and pins were used, and not involving the wider team when dealing with infections.

What are the implications for patients?

If surgery is not clearly needed or in the patient's best interests, it can lead to unnecessary procedures that put the patient at risk. When doctors do not take a full history, examine the patient properly, or review test results carefully, they may misdiagnose the problem and choose the wrong treatment. Choosing an unusual method without a clear reason or proper oversight adds unnecessary risk, especially if the approach isn't proven.

When decisions are based on personal preference instead of a thorough assessment and recognised guidelines, patients and families may not be told about safer or alternative options. Poor communication and incomplete records make it hard to understand why decisions were made.

Of those patients treated by Mr Jabbar, where harm was identified, patients were subject to:

- Inappropriate or poorly documented surgical strategies, such as a singular correction, rather than a progressive incremental correction and inadequate surgical fixation.
- Insufficient safety netting advice (providing patients with clear information about when to seek further medical help if their condition does not improve or new worrying symptoms appear) in follow-up.

Identification, Management and Ownership of Complications

What is standard practice in the UK?

Doctors must spot complications quickly and act straight away to keep the patient safe. This means checking the patient promptly, raising concerns when needed, and using treatments that are evidence based and risk assessed. They should explain clearly to the patient and their family what has happened, what will be done, and what the likely outcome is. If something goes wrong, doctors must be open and honest, report the problem, and make sure it is properly investigated so lessons can be learned.

Taking responsibility is essential. Doctors should not shift blame but own the decisions and care provided. They need to work closely with colleagues, call in specialists when necessary, and make sure the child or young person's care continues smoothly. Records must be clear, accurate, and written at the time, showing what happened, what was done, and what was discussed with the patient and family.

What were the findings of the review in relation to Mr Jabbar's clinical practice (identification, management and ownership of complications).

Standard practice: There were examples of prompt recognition and effective management of complications, including timely surgical intervention, multidisciplinary escalation, and appropriate antibiotic use. In some cases, clear communication with families and robust follow-up supported patient safety and functional recovery.

Sub-standard practice: Delayed or missed identification of serious complications, limited Consultant oversight and onward referral, and inadequate documentation of discussion of adverse events with other team members. There were evidence of inconsistent postoperative reviews and a lack of action despite concerning findings. There were instances when patients appeared to have a complication of surgery, yet their symptoms were misattributed to an alternative diagnosis.

Issues with recognising and addressing complications, as well as insufficient intraoperative safeguarding of neurovascular structures and inadequate preparation of the bone for fusion surgeries, further highlighted areas needing improvement.

What are the implications for patients?

If problems after surgery are not spotted quickly and dealt with appropriately, the patient could come to harm. Their condition might get worse, recovery could take longer, or the situation could even become life-threatening. Delays in raising concerns or using unrecognised treatments can lead to care that is unsafe or ineffective. When doctors don't explain clearly what went wrong and what will happen next, patients and families are left worried and confused, which damages trust and makes it hard to make decisions together.

Of those patients treated by Mr Jabbar, where harm was identified, patients were subject to:

- Delayed recognition or management of complications such as compartment syndrome, infection, non-union, malalignment, and neurovascular injury with limited onward specialist referral and inconsistent consultant oversight.
- Incomplete documentation around complications and infected implants.

Chapter 4: Wider Learnings and Actions

In this chapter we describe the findings of the review into the Orthopaedic Service and the actions we have taken as a result to improve the service and services across the hospital. We have reflected on what has happened and asked ourselves what more we can do to make our services safe and therefore have also set out the additional actions we are taking.

Improving the Orthopaedic Service

The Royal College of Surgeons Review

As described earlier in this Report, as well as reviewing the care provided by Mr Jabbar, we asked the RCS to review the Orthopaedic and LLR Services through their invited review service. Whilst conducting the initial investigation we found evidence that indicated broader concerns about ineffective teamworking in the LLR service. As such, an invited review from the RCS was considered the most appropriate way to explore these concerns and to identify any areas of improvement impartially.

The RCS produced two reports: one into the service; and the other into the practice of the two Surgeons. As is described earlier, they raised serious concerns about the practice of Mr Jabbar which led to our patient recall process. The practice of the other Surgeon was found to be of a good standard.

We received the report into the service – the Service Review - on 31 October 2023. It highlighted areas of good practice and areas of concern that had the potential to impact on patient safety and care.

The areas of concern included:

- Team working, communication, behaviours, inclusivity, culture, and the effectiveness of MDT working.
- Identification, management, and discussion of complication rates.
- Effectiveness of existing clinical governance practices.
- Management of patient referrals, follow ups and waiting lists.

The RCS did not ask or recommend for the practice of any other member of the team to be reviewed.

The report highlighted the many committed staff who worked hard every day to deliver the best care possible to their patients. The reviewers also said that despite the challenge and constraints they found, they were impressed by the quality and standard of care being provided by staff, and their passion and commitment towards providing excellent support and communication to patients and their families, as well as to each other.

Royal College of Surgeons Report Recommendations

The RCS made a total of 122 recommendations for the hospital to consider. We accepted all the recommendations, and we established the Orthopaedic Service Improvement Board in April 2024 to oversee the actions required to address the recommendations.

A comprehensive action plan was developed to address the recommendations, with the recommendations grouped into the following themes:

- Trust wide / corporate actions.
- Team working, unity and communication.
- Clinical record keeping.
- Outpatient processes.
- MDT processes.
- M&M processes.
- Patient recall.

All the RCS recommendations have been fully addressed, and in response to our update provided on 9 October 2025, the RCS stated that considerable progress has been made, with a good foundation in place in order for the Orthopaedic Service to move forward. Given the work that has taken place and the programme of work which remains in progress, they have concluded their active follow-up of this review. This conclusion is based on the hospital seeing through the remaining actions.

Orthopaedic Service Improvement Programme – Areas of Focus

Ensuring the Orthopaedic Team had the right resources and support

Supporting the Orthopaedic Team and rebuilding as a collective was key to enabling improvements and changes in practice. We recognised that the review findings were challenging for them and had impacted relationships within the team and with the Senior Leadership Team (SLT).

To support this work, we appointed an Interim Speciality Lead who had extensive experience in clinical leadership. Regular meetings between clinical and senior operational leaders were established to improve communication, identify issues early, and solve problems collectively. Key areas of improvements in practice are detailed in the section below.

We have recruited two new Consultant Surgeons; one specialises in Paediatric Limb Reconstruction and the other has a specialist interest in neuromuscular conditions. These two appointments addressed the vacancy left by Mr Jabbar and increased the workforce by an additional surgeon as recommended by the RCS.

New Referral and Follow-up Patient Processes

A standard process is now in place which governs the way the Orthopaedic Service accepts new patients, manages its waiting lists, and how it schedules appointments. Since the Review, the time taken for new referrals waiting to be seen has improved, and there are fewer patients waiting for appointments.

A “Consultant of the week” system has been introduced so that one specific Consultant is responsible each week for reviewing incoming referrals. Clear referral acceptance and rejection criteria and guidance have been agreed to ensure referrals to this highly specialised service are appropriate. When the service cannot accept a referral, advice is sent to the referring team.

Improving Multi-Disciplinary Team and Mortality and Morbidity (M&Ms) processes

When complex specialist care and treatment is being planned and considered, it is important that a range of professionals are involved in discussions around care. Two ways this can routinely take place are through effective MDT and M&M meetings.

MDTs, otherwise known as peer-support meetings, are meetings where a number of different surgeons, together with other professionals, input into the plans for complex care before and during delivery to ensure the best possible outcomes. These discussions are also a way to identify and discuss differences in clinical practice which may lead to concerns being raised.

M&Ms are meetings that allow clinical staff to reflect upon and discuss complications, unexpected events and adverse outcomes.

The RCS Service Review highlighted a need to improve the processes around the MDT and M&M meetings within the Orthopaedic Service. To address this, clear terms of reference were introduced for each meeting which define the purpose, membership, and expectations for behaviours in these meetings. A standardised process for preparing, presenting, and documenting cases at both meetings has also been added into the electronic patient record system.

The improved MDT process now ensures that all planned orthopaedic operations are discussed in a formal fortnightly meeting before surgery to agree that the surgical approach is appropriate, and again after surgery to review its outcomes. These meetings involve the Orthopaedic Consultants, a Radiology Consultant and a number of Allied Health Professionals (including Specialist Nurses and Theatre Nursing staff).

Surgeons from GOSH also now meet fortnightly with Orthopaedic Surgeons and other clinicians from the Royal National Orthopaedic Hospital (RNOH). This face-to-face meeting provides an opportunity for combined case discussions, with early identification of challenges, and for sharing experience and knowledge to suggest where adjustments to surgical plans may be beneficial.

These discussions help to ensure the best possible surgical plan is devised for the patient. For the GOSH Consultants, the focus is to discuss complex limb reconstruction cases that may be outside the sphere of expertise of the other surgeons in the Orthopaedic department at GOSH. This would include all patients for whom circular external fixator frames are being considered, in keeping with a recommendation for the RCS Review.

Records of these joint meetings show comprehensive and supportive discussions. Patients and families in these complex cases, where management is particularly difficult, are informed in advance that their case will be discussed in these meetings and are then kept informed of the outcomes of discussions. Patients and families have reported their appreciation of this process.

The pre-existing M&M meetings continue as a separate process to the MDT meetings. Patients whose care does not go to plan are identified by the Orthopaedic Team and discussed in detail at this monthly meeting. These discussions help identify factors (including surgical, medical, nursing, or administrative) that may have influenced undesirable outcomes and highlight potential improvements.

Developing Outcome Measures

There are currently no internationally agreed outcome measures for paediatric patients with lower limb reconstruction needs, and very few units in the UK are collecting such data. The team of clinical staff that work to care for orthopaedic patients, and in particular the Physiotherapy team, have reviewed the specific outcome measures for children and young people with limb differences that are available internationally and have agreed on a system that they feel is most appropriate to guide and assess treatment for our patients at GOSH. This work is being presented at national conferences in the UK in 2026.

The team have also agreed outcome scores for conditions that affect the foot and ankle and for neuromuscular conditions that require orthopaedic surgery.

Understanding and Improving Team Culture

Those staff from the Orthopaedic Service and teams that support them, who had been interviewed as part of the RCS review, took part in follow-up interviews led by our Human Resources (HR) team. The follow-up interviews took place in February 2025 and were to understand whether the improvement work had resulted in the Orthopaedic Service feeling different to work in, specifically related to teamwork and behaviours.

The results showed improvements in the team culture, with staff reporting positive changes. They also identified future priorities, including the recruitment of a Specialty Lead from within the service. This Specialty Lead is now in place.

Improving Wider Services at the Hospital

Our patient safety statement was approved by the GOSH Board in February 2023, which cements our commitment to listen, learn, and lead to ensure that we deliver high-quality and safe care to our patients and families.

As part of this commitment when we have concerns about any individual member of staff or service, we will not hesitate to undertake a review to ensure that the care we provide is of a high standard. Where it is not, we have a duty to learn from what we have found and to ask ourselves if there are wider learnings and actions we must take in other areas of the hospital.

Actions arising from the Review

In addition to the actions detailed above to improve the Orthopaedic Service and the care it provides, the RCS made a number of ‘corporate recommendations’ for the hospital to take forward.

These included:

- The hospital making dedicated efforts to build stronger links with RNOH.
- Improving the way complaints are responded to.
- Ensuring there are formalised, robust and transparent ways for staff to raise concerns.
- Improving staff induction and training to better integrate incoming staff.

Taking these in turn:

Building stronger links with RNOH

As detailed above we now have a fortnightly MDT meeting involving members of staff from both clinical teams. A monthly Partnership Board meeting takes place between GOSH and the RNOH, which include members of the Executive and Senior Leadership Teams of both Trusts. This oversees the exploration of opportunities to collaborate across the full range of orthopaedic clinical and clinical support activities, including transition from children and young people’s services to adult services. Both organisations are working together within the region to identify how to improve outcomes, access, patient experience, quality and clinical efficiency of children and young people’s Musculoskeletal services across North Central London.

Improving the way complaints are responded to

Complaints training was delivered to the Directorate Leadership Team which oversees a range of services including orthopaedics in January 2024. The complaints training covered:

- Understanding what a formal complaint is and how they are managed.
- Guidance on how to conduct a thorough investigation into a formal complaint.
- Increased awareness of the tools to support an investigation of a complaint.
- How to write a formal complaint response.
- Guidance on appropriate tone.
- Apologies when writing a response.

Ensuring there are formalised, robust and transparent ways for staff to raise concerns

We know that a keyway of being alerted to potential issues with care is by all staff speaking up. As explained earlier we were alerted to potential issues with Mr Jabbar’s practice after a colleague raised concerns and we are grateful for the staff member who did this.

The ways in which staff can raise a concern are detailed in our Freedom to Speak Up Policy and we undertake a continuous programme of education to ensure our staff are aware of all the routes - internally and externally – they can use.

Our Freedom to Speak Up Guardian (FTSUG) service is an important way staff can speak up although we know that speaking up happens across the hospital in many other ways too. In the last year we have doubled the FTSUG Service’s resource which has allowed us to be more proactive in developing a Speak Up culture. Work has included going out to target hard to reach areas and areas where there has been low reporting. We also ask all staff to complete the National Guardian’s Office Speak Up and Listen Up training.

The latest data on FTSUG cases shows that we are in the highest quartile nationally for the proportion of staff speaking up. While we know some barriers still exist to speaking up, we have already seen examples where members of staff have spoken up where something has not felt quite right with outcomes and we have then been able to review services with the clinical teams to ensure the care is of the standard we, and our patients and their families, expect.

Improving staff induction and training to better integrate incoming staff

We have reviewed and updated our induction programmes for all Consultants with an increased focus on job planning and team responsibilities and accountabilities. A peer support group for Consultants who have under five years’ service has also been set up. We are also currently training the first cohort of mentors to support a mentorship scheme for new Consultant colleagues.

Actions arising from our reflections on what has happened

Whilst the RCS report focused specifically on the Orthopaedic Service, there were lessons and recommendations within it that have broader implications and opportunities for GOSH.

GOSH has therefore developed a hospital-wide Quality and Safety Improvement Programme (QSIP). This builds on an existing programme of patient safety transformation.

This programme is overseen by the Executive Management Team and has been co-created with the Senior Clinical Leadership Teams to deliver the changes identified by the RCS as well as findings from the recent Surgical and Well Led inspections by the CQC in 2025. GOSH recognises that it cannot operate in isolation, and there have been several significant national publications recently which alter the way NHS Trusts view quality, safety, and patient experience. These publications will be considered within the QSIP to ensure that GOSH continues to learn from others.

The QSIP is structured across several phases. Our current phase which runs to March 2026 includes the following priority areas:

- Strengthening meeting governance in relation to MDT meetings and M&M meetings across all of our specialities.
- Training and development programme for Speciality Leads to ensure they have the necessary skills and expertise to lead their speciality.
- Supporting the smooth running of the speciality through service level planning; an annual agreement that defines the duties, responsibilities, and objectives for all Medical Consultants.

Progress Against Trust Wide Actions

MDT and M&M Meeting Governance

We are undertaking a large piece of work to standardise MDTs across the hospital. We started by reviewing national and international guidelines and good practice to agree a definition and generic Terms of Reference.

We are now working with all our specialties to ensure that they have up-to-date terms of reference and a nominated chair for every MDT meeting. We are also focussing on how the meetings are run to ensure consistency and quality of our documentation, and to raise the profile of all voices within an MDT. To support this, we are working with all chairs to focus on skills such as managing conflict, behaviours, consistent documentation, actions, and identifying themes.

As with MDTs, we are undertaking a large piece of work to standardise M&M meetings. We have reviewed national and international guidelines and good practice and are agreeing a definition and generic Terms of Reference. We have set up a Task and Finish Group to look at M&M documentation to agree a standard process and how we gather cross organisational themes.

Reviewing Outcome Measures for Our Services

Many of our services have nationally agreed outcome measures which are reported and allow us to compare our clinical outcomes with others and therefore identify any variances.

However, we know in some services like LLR there are no nationally agreed outcome measures. We are doing a comprehensive piece of work to identify the services where there are no nationally agreed outcome measures and are now working with our teams and national and international peers to discuss what measures we could use.

We have also developed a proposal to set up an outcomes workstream through the Children's Hospital Alliance (CHA). This is being actively discussed with the CHA and would see us work with other children's hospitals and services across the UK to establish a clinically meaningful approach to benchmarking outcomes for low-volume, high-complexity paediatric services.

Investing in our clinical leaders

Effective leadership is key to a high functioning team and delivering safe care. For each of our clinical specialties we have a Specialty Lead. We are co-creating a leadership programme with these leads. It has already delivered two managing doctors masterclasses to over 40 senior members of staff, and a one-year development course is planned to start in April 2026. The course will support learning within three domains described below:

1. Self-Leadership and Leading Teams

This is about leaders understanding themselves first — their strengths, weaknesses, and values — so they can lead others effectively. It also covers how to motivate and support teams, helping everyone work well together.

2. Organisational Leadership and Management

This focuses on running a department or service within the NHS. It is about planning, managing resources, and making sure things get done efficiently while keeping patients, families, and staff at the heart of decisions.

3. System Leadership

This is about looking beyond the leader's team or organisation and thinking about the bigger picture — how different parts of the NHS and social care work together. It is about collaboration across boundaries to improve care for the whole community.

We anticipate that our leads will develop a community of practice, learning and sharing with each other, exchanging ideas, solving problems together, and supporting each other to keep improving.

Supporting Patients to Raise Concerns

We work hard to ensure our staff are able to respond directly to concerns raised by patients and families, and/or to signpost feedback pathways as and when issues arise during the course of a child or young person's care. We appreciate that patients and families may have issues they feel have not been addressed and therefore support them to raise concerns through a number of other routes.

A keyway we aim to listen and resolve concerns is through our PALS team – often the first port of call for patients and families. In addition to this, patients and families are able to share any feedback (including any concerns or issues) through the Friends and Family Test feedback processes (via paper cards or electronically). Staff from Patient Experience review feedback received to ensure that it is being managed through the appropriate process and that that it is followed up appropriately. Information about ways to raise any issues and/or share feedback are promoted through the hospital including but not limited to posters, information on bedside entertainment systems, via MyGOSH (the electronic health record app) and patient information.

Of note, we robustly monitor PALS contacts and triangulate with other data sources such as complaints and other feedback to identify any themes/areas that we need to look into.

Martha's Rule

Martha's Rule was introduced into the NHS following the tragic events which led to the death of Martha Mills following a bicycle accident. It provides a way for patients, families, and staff to raise concerns they may have about themselves or a patient and receive a second opinion.

The concerns are addressed by the Clinical Site Practitioners, who are advanced nurses who provide care for unwell children, support staff and families and oversee emergency admissions and staffing out of hours. They provide an opportunity for those concerned to discuss any worries or deterioration with someone impartial.

GOSH acted as a pilot site for the roll out of Martha’s Rule and it is now in place across our hospital. Although this is in place, and has been utilised by families, we know we need to improve the visibility of the programme for families and make it clearer exactly how they seek advice.

Chapter 5: Next Steps

Support to Patients and Families

We are deeply sorry to all the children, young people, and their families who have come to harm or have been impacted by these events. We also recognise that the findings within this report will be difficult for some patients and their families to read and we are very sorry for any distress that this causes.

Psychological support remains available for any patients and their families impacted. If you feel you would benefit from this, please contact the Patient Advice and Liaison Service (PALS) on 020 7829 7862 or by emailing pals@gosh.nhs.uk. In addition, if you have any general questions or need to discuss any of the elements in this report, please also contact our PALS team.

The NHS has a list of charities and organisations who may be able to provide support, and these can be found at www.gosh.nhs.uk/orthopaedic-review. Alternatively, you can also seek support from your General Practitioner (GP), and you can also find helpful advice and support from AvMA, a charity for patient safety and justice (www.avma.org.uk).

We appreciate families may wish to discuss their own concerns directly with the Police and can do so via normal routes including calling 101 or visiting their nearest station. For more information visit https://www.police.uk/pu/contact-us/.

Working with Other Organisations

We have been working closely with our Local Authority Designated Officer (LADO) to keep them informed of our work. The LADO is a safeguarding professional who is responsible for overseeing concerns, allegations, or incidents involving individuals working with children and young people.

They work with multiple organisations including social care, the Police, and employers to manage allegations and take any steps necessary. Informing them of our work to recall patients for review is a standard part of our 'Working Together to Safeguard Children' guidance.

NHS England Independent Patient Safety Investigation

After receiving the RCS report, GOSH began to explore commissioning an investigation, led by an independent party, to understand whether there were any missed opportunities to prevent the harm that occurred prior to concerns being raised. This was widely supported within the hospital, and oversight was to sit with the Non-Executive Directors on the Trust Board.

After sharing plans with NHS England, it was agreed that NHS England London region would commission an independent patient safety investigation to review the responsiveness of GOSH when potential harm was identified within the complex clinical pathway for the limb lengthening service.

The investigation will focus on governance and organisational culture at GOSH and aims to:

- Promote openness and transparency about what occurred and the factors involved.
- Identify opportunities for improvement to reduce the likelihood of similar events in the future.

- Provide actionable recommendations to strengthen the delivery of health services across relevant organisations.

This review is intended to complement the RCS assessments by concentrating on systems and processes rather than individual cases or clinical harm.

It is something that the hospital welcomes and we will work with the appointed company to ensure that we are able learn from these events and ensure that steps are taking to reduce the risk of a similar incident taking place in the future.

Chapter 6: Glossary

Term	Definition
Acute correction	Correction of a deformity in a single surgery rather than a gradual correction
Amputations	Surgery to remove part of a limb.
Bone grafts	Small pieces of bone (from your child or a donor or synthetically made) used to fill gaps or support bone healing.
Casting	A hard protective shell (plaster or fibreglass) that holds a limb in place while it heals.
Circular frames	A circular frame in orthopaedic surgery is a medical device used on the outside (external) of the leg or arm to provide stability and the allow surgeons to make small adjustments of bone positioning during healing.
Clinical Nurse Specialists	Senior Nurses with expertise in the specific speciality who provide expert care, manage cases, advocate and support patients and their families through their health care journey
Clinical priority	How urgently care or surgery is needed, based on safety and benefit for the child.
Compartment Syndrome	A rare emergency where pressure builds in a limb and threatens blood and nerve supply—needs urgent care.
Conservative management	Treating a medical condition using the least invasive, non-surgical methods
Consultant Paediatric Orthopaedic Surgeon	A Senior Children's Bone and Joint Surgeon who leads surgical care and decision-making.
Deformity	Where a part of the body has not developed in the usual way or does not have the usual shape.
Deformity planning	Careful measurement and imaging used to plan the safest, most effective way to straighten or correct a deformity.
Duty of Candour	A legal duty for NHS organisations to be open and honest when care may have caused harm, including an apology and explanation.
Epic	Epic is a supplier of electronic patient record systems. All patient notes, investigations and theatre records are within Epic patient records. *GOSH went live on the Epic system in 2019.
External metalwork	Any metal device on the outside of the limb, such as frames or pins attached through the skin.
Fixation	Holding broken or cut bones steady using plates, screws, pins, or nails so they can heal.

Fracture	A broken bone.
General anaesthetic	Medicine that sends the patient to sleep so they feel no pain during an operation.
General Medical Council	A public body that regulates Doctors, Physician Associates, and Anaesthetic Associates in the United Kingdom.
Holistic approaches	Looking at the medical, physical, emotional, and social aspects when planning care.
Implants	Medical devices like screws, plates, rods, or nails placed in the body to support bones.
Inadequate fusion preparation	Not preparing bone or joint surfaces well enough before fusion, which can reduce the chance of solid healing.
Insufficient stabilisation	The bone wasn’t held firmly enough by the metalwork, risking poor healing or movement.
Interventional Radiology	A medical specialty which uses image-guidance to perform surgery through small incisions.
Intra-operative imaging	Taking medical images during a surgery, in real time, to help the surgical team see what’s happening inside the body as they operate
Intra-operative safeguarding of neurovascular structures	Protecting nerves and blood vessels during surgery so they aren’t stretched, trapped, or injured.
Invasive surgical technique	A procedure that involves cuts into the body or insertion of instruments to carry out treatment.
Lengthening nails	Telescopic metal rods placed inside the cavity of a bone that slowly lengthen it over time.
Limb lengthening	Medical treatment that helps make a leg or arm bone longer by using the body’s natural ability to grow new bone
Limb reconstruction	Specialist surgery and support to rebuild or correct a limb’s bones and soft tissues.
Malalignment	A bone or joint that is not in the correct position.
Metal plates	Metal strips screwed to bone to keep it stable while it heals.
Metalwork	The screws, plates, rods, or wires used during surgery to hold bones steady.
Methodology	The agreed way the review or study is carried out—including what is checked and how decisions are made.
Misdiagnoses	When the original diagnosis turns out to be wrong.
Morbidity and Mortality Meeting	A regular safety and learning meeting where the team reviews complications and outcomes to improve care.
Multidisciplinary Team Meeting	A planned discussion where all the professionals involved in a child’s care agree the best plan together.

Neuromuscular conditions	Medical conditions that affect the way your nerves and muscles work together.
Neurovascular assessments	Physical checks of blood flow and nerve function in a limb (colour, warmth, pulses, movement, and sensation), usually comparing the affected limb to the other.
Neurovascular status	The current blood supply and nerve function in a limb.
NHS England	The national organisation that oversees how the NHS runs in England.
Non-union	A broken bone that has not healed.
Nurses	Registered professionals who provide day-to-day care, monitoring and support for children and families.
Occupational Therapists	Specialists who help children do everyday activities (dressing, school, play) using exercises, equipment, or adaptations.
Orthotists	Clinicians who design and fit braces, splints or insoles to support limbs, improve alignment or function.
Osteotomy levels	The exact place(s) in a bone where it will be cut to change shape or alignment.
Outcome measures	Simple scores or tests used to track how well treatment is working (for example: pain, movement, daily function).
Peer review	Peer review is a process where medical experts check each other's work to make sure it is accurate.
Physiotherapists	Movement and exercise specialists who help children build strength, improve mobility, reduce pain, and recover.
Pin-site infection	Redness or infection around a pin that goes from a frame into the skin; usually minor and treatable.
Play Specialists	Staff who use play to prepare, distract, and comfort children before, during and after procedures.
Post-operative fracture	A break in a bone that happens after surgery.
Prevalence	How common something is - e.g., how many children out of 100 have a condition.
Psychological support	Help from mental-health professionals to cope with feelings, stress or trauma linked to illness or treatment.
Psychologists	Professionals who help children and families with emotions, coping strategies and behaviour.
Psychosocial factors	Family, school, emotional and social influences that affect a child's health and recovery.
Radiographic findings	What X-rays or scans show.
Recall Pathway Workstreams	The strands of work that handle reviewing care and tracking progress for the orthopaedic review.

Reparative Pathway Workstreams	The strands of work that handle further treatment when reviews find care needs to be amended.
Resident Doctor	A fully qualified Medical Doctor who is still undergoing postgraduate training. They have finished medical school but are not yet a consultant or GP. They work in hospitals (or sometimes GP practices) while continuing their training and gaining experience.
Risk counselling	A discussion between a clinician and a patient to inform the patient about the potential risks and benefits of their care.
Safety and Quality Strategies	The hospital's plans to improve safety and the quality of care over time.
Safety Transformation Programme	A hospital-wide improvement programme to strengthen patient safety systems and culture.
Safety-netting advice	Clear guidance on warning signs to watch for and when to seek help after you go home, usually given during the discharge process
Senior Responsible Officer	The executive leader accountable for an improvement programme's delivery and oversight.
Staged Observations	Refers to a medical approach where a patient is monitored and reassessed at set intervals.
Suboptimal implant positioning	The screws, plates or intermedullary nails are not in the best place, which can affect alignment or healing.
Terms of reference	A written document that sets a meeting's purpose, membership and how it works.
The Royal College of Surgeons of England	An independent professional body and registered charity that promotes and advances standards of surgical care for patients and regulates surgery and dentistry in England and Wales.

Appendix A – High-Level Timeline

Date	Event
June 2017	Mr Jabbar joins GOSH
6 May 2021	Serious Incident Investigation concludes
15 June 2022	Concerns raised to Chief of Service
11 July 2022	Initial approach to Royal College of Surgeons
August 2022	Clinical practice restricted to non-complex surgery
September 2022	Review formally commissioned with the Royal College of Surgeons
1 October 2022	Mr Jabbar starts unpaid sabbatical
February, April and May 2023	Royal College of Surgeons visits GOSH
12 June 2023	Mr Jabbar formally resigns from GOSH
31 October 2023	Royal College of Surgeons Service Review Report received
29 May 2024	First patient review completed
24 October 2025	Patient recall concludes

Appendix B - Patient Recall – Breakdown of Figures

Identifying patients for review

Table 5: breakdown of patients identified for review.

Patient group	Number	Cumulative
Patients with Mr Jabbar's name included in their medical records	851	851
Patents initially excluded from review cohort because there was little evidence to suggest significant contact with Mr Jabbar	(130)	721
Patients added to the review cohort following family contact with PALS	2	723
Patients added to the review cohort following re-evaluation of medical records	97	820
Patients removed from GOSH's cohort as it was determined the most significant area of their care was delivered by another hospital	(37)	783
Patients who were determined to have the most significant aspect of their care delivered by another hospital, BUT their review had already been done by GOSH	6	789
Total patient review cohort led by GOSH		**789**

Table 6: patients by clinical prioritisation category

Category	Total patients by categories
1	149
2	117
3	15
4	411
5a	60
5b	37
Total	**789**

Appendix C – Harm Definitions

NHS England has established guidelines on how to assess clinical harm and the gradings that are applied. Full information can be found at: NHS England » Policy guidance on recording patient safety events and levels of harm

For the purposes of the GOSH review of patient care, only physical harm was assessed. This is because the independent experts were Orthopaedic Surgeons, not mental health professionals, and as such were not themselves in a position to assess or diagnose psychological harm.

Table 7: Gradings of harm as per NHS England guidelines

Level of Harm	Physical Harm
No Harm	Any patient safety event that had the potential to cause harm but was prevented, resulting in no harm, or any patient safety incident that occurred, but no harm was sustained by the patient. No physical harm has been sustained.
Low/Mild	Low physical harm is when **all of the following** apply: • Minimal harm occurred – patient(s) required extra observation or minor treatment. • Did not or is unlikely to need further healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit. • Did not or is unlikely to need further treatment beyond dressing changes or short courses of oral medication. • Did not or is unlikely to affect patient's independence. • Did not or is unlikely to affect the success of treatment for existing health conditions.
Moderate	Moderate physical harm is when **at least one** of the following apply: • Has needed or is likely to need healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit, and beyond dressing changes or short courses of medication, but less than 2 weeks additional inpatient care and/or less than 6 months of further treatment and did not need immediate life-saving intervention. • Has limited or is likely to limit the patient's independence, but for less than 6 months. • Has affected or is likely to affect the success of treatment, but without meeting the criteria for reduced life expectancy or accelerated disability described under severe harm.
Severe	Severe harm is when **at least one** of the following apply: • Permanent harm/permanent alteration of the physiology • Needed immediate life-saving clinical intervention.

	• Is likely to have reduced the patient’s life expectancy. • Needed or is likely to need additional inpatient care of more than 2 weeks and/or more than 6 months of further treatment. • Has, or is likely to have, exacerbated or hastened permanent or long term (greater than 6 months) disability of their existing health conditions. • Has limited or is likely to limit the patient’s independence for 6 months or more.