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MSc Public Health and Social Care in Practice

MODULE CODE AND TITLE:	LCHS7002
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ASSIGNMENT TITLE:	Case Study Analysis Report
TOPIC:	Case study number 4 – Lewis Blackman [Case of medical malpractice and negligence]

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Date of submission: 21ST April 2026

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1. Introduction

The case of Lewis Blackman is a well-known example of medical malpractice and failures in the healthcare system (Haskell, 2004; Institute of Medicine, 2000). It points to significant problems of patient safety, communication and leadership. Lewis Blackman was a 15-year-old boy who died following routine surgery because of the complications which were not identified and inadequate clinical judgments made by medical personnel (Haskell, 2004). His mother, Helen Haskell, informed the world about the inefficiencies of the healthcare system and explained the existence of cognitive bias, power imbalance, and disjointed care, which led to this avoidable tragedy (Reason, 2000). The case gives a chance to discover what leadership can do to enhance the quality of healthcare and avoid such incidents (Institute of Medicine, 2000).

Health and social care leadership implies influencing, guiding, and supporting individuals or teams towards the realization of shared objectives, particularly the delivery of safe, effective, and patient-centered care (Northouse, 2019). The presence of strong leadership is important in complicated healthcare environments where the professionals should collaborate, make crucial decisions, and react to dynamic circumstances (West et al., 2015). Leadership is not only the prerogative of those in formal authority, leaders may be portrayed in their actions, communication and holdability at all tiers of care delivery (NHS Leadership Academy, 2013). On the other hand, poor leadership results in communication failures, decision delays, and unsafe working situations, which can be observed in this case [Northouse, 2021; NHS England, 2019].

The centralisation and decentralisation are organisational structures that play a key role in leadership practices (Mintzberg, 1983). Centralisation is the process of decision-making being made at greater levels of authority and therefore consistency but may take a long time to respond to an urgent situation (Burns and Stalker, 1961). Decentralisation enables the distribution of decision-making power throughout the various levels and this encourages flexibility and swift reaction but only with good coordination and communication (Mintzberg, 1983).

The leadership theories and styles also influence the way leaders operate (Goleman, 2000). Transformational leadership is aimed at inspiring and motivating the teams towards the shared vision, promoting innovation and change (Bass and Riggio, 2006). Transactional leadership is more focused on structure, supervision and performance-based rewards or penalties (Burns, 1978). Situational leadership varies strategies according to the group requirements and the situation (Hersey, Blanchard and Johnson, 2013). The selection of an appropriate leadership style is particularly significant during crises or changes, when decisions made within the time limits, effective communication, and teamwork can significantly influence patient outcomes (Goleman, 2000).

This report will investigate the Lewis Blackman case of leadership and management in healthcare. It will delve into the role of leadership failures in the incident, explain the impacts of organisational structures and power dynamics, and evaluate the leadership styles that could have worked. It will demonstrate the role played by leadership, organisational structure and system failures in the negative outcome. Lessons learned and recommendations to enhance leadership practices to guarantee patient safety and quality care will also be shared in the report (West et al., 2015).

Main Body

2. Identifying the Problem and Setting the System Context (Lewis Blackman Case)

2.1 Central Problem

The key problem with the case of Lewis Blackman is that in spite of avoidable clinical communication failure, delayed escalation of care, and hierarchical obstacles in the hospital system, a 15 year old patient died. Lewis had complications of internal bleeding after a regular operation. Nevertheless, the presence of repetitive warning symptoms such as intense pain, abnormal vital parameters, and parental issues were not attended to timely.

This led to an urgent diagnosis and intervention failure, and cardiac arrest and death. The case illustrates that disjointed care delivery, lack of clinical judgment due to pressure, and inefficient communication may cause deadly consequences (Haskell, 2015).

2.2 Global Statistical data

Unsafe healthcare continues to be a significant societal problem in the world. According to the estimates of the World Health Organisation, there are:

- ✚ 1 out of 10 patients in the global healthcare environments is injured (WHO, 2019).
- ✚ Over 3 million deaths annually are linked to unsafe care in low- and middle-income countries (WHO, 2019).
- ✚ About 42 billion is spent on medication errors alone worldwide annually (WHO, 2017).

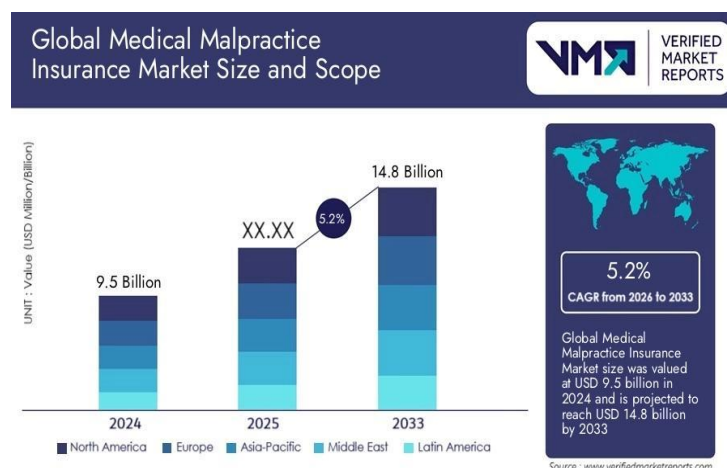


Figure 1 : Global medical malpractice insurance market size and scope

The Bar chart shows the global medical malpractice insurance market growing from \$9.5 billion in 2024 to \$14.8 billion by 2033, with steady annual growth.

The connection is that cases like the **Lewis Blackman** highlight the serious consequences of medical negligence, which in turn drives more awareness, legal claims, and demand for malpractice insurance.

As incidents of negligence become more visible through such cases, more patients and families seek legal action. This contributes to the rise in medical malpractice claims—helping explain why the global malpractice insurance market is growing steadily.

These figures serve to emphasize the fact that the Lewis Blackman case is not an isolated event but instead a symptom of a bigger world trend of avoidable harm due to systemic failures as opposed to individual negligence.

In terms of systems, the case illustrates latent conditions including the inadequacy of training, supervision and inappropriate implementation of escalation procedures which are in tandem with the international patient safety issues (Reason, 2000).

2.3 UK / NHS Perspective

Patient safety incidents are a major problem in the National Health Service in UK. The NHS patient safety report data reveal:

- Hundreds of thousands of patient safety incidents are reported every year (NHS England, 2023).
- Much of it consists of communication breakdown and treatment delays.
- Absence of escalation of deteriorating patients is a frequent theme in serious incident investigations (NHS England, 2023).

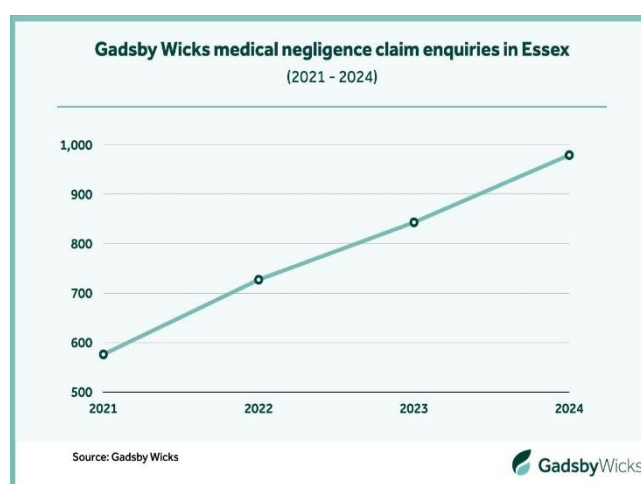
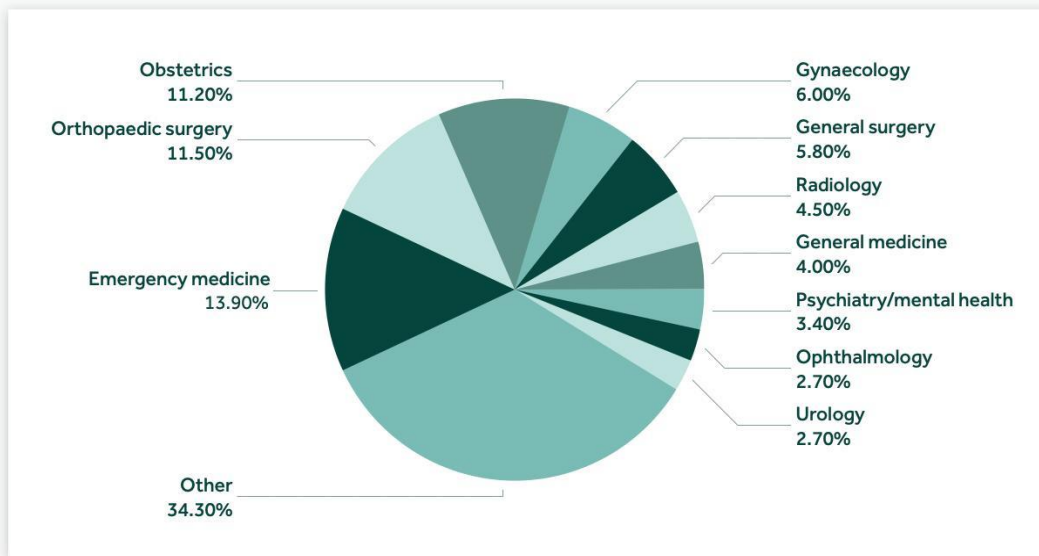


Figure 2 : Medical negligence claim enquiries in Essex ; Gadsby Wicks, 2024

- This line graph shows that a steady increase in medical negligence enquiries from about 600 in 2021 to nearly 1,000 in 2024.

Types of medical negligence claims received by NHS Resolution (2024/25)



Source: NHS Resolution

GadsbyWicks

Figure 3: Types of medical negligence claims received by NHS Resolution (2024/25)

The pie chart shows how different medical specialties contribute to negligence claims.

- The largest category is “**Other**” at **34.3%**.
- **Emergency medicine** accounts for **13.9%**, followed by **orthopaedic surgery (11.5%)** and **obstetrics (11.2%)**.
- Smaller shares include **gynaecology (6.0%)**, **general surgery (5.8%)**, **radiology (4.5%)**, and **general medicine (4.0%)**.
- The lowest proportions are **psychiatry/mental health (3.4%)**, **ophthalmology (2.7%)**, and **urology (2.7%)**.

The **Lewis Blackman** case is most closely connected to categories like **emergency medicine**, **general medicine**, and surgical care shown in the chart. His death involved failures in monitoring, communication, and response to complications after surgery issues that commonly appear in high-claim areas such as emergency and surgical specialties.

So, the chart reflects how the type of negligence seen in his case is not isolated; it falls within the same medical areas that frequently generate claims, helping explain why these categories have significant percentages.

Own observations of the Care Quality Commission have pointed out on many occasions:

- Poor multidisciplinary communication.
- Inadequate clinical handovers.
- Lack of responsiveness to patient deterioration (CQC, 2022).

These findings reflect the systemic failures seen in the Lewis Blackman case, especially the failure to recognize and respond to clinical deterioration.

Global Comparisons and National Organisations

- The systematic nature of the issue is further supported by insights provided by such organizations as the Institute of Healthcare Improvement:
- Failed communication is a major cause of more than 60 percent of the major adverse events (IHI, 2018).
- Delay in escalating care is one of the major contributors to avoidable deaths in hospitals.
- High-reliability organisations emphasize the need of flattened hierarchies and open communication cultures (IHI, 2018).

On a global and national scale, these results are consistent with the case of Lewis Blackman where:

- Junior employees were afraid to speak out.
- Observations made by nurses were not put into action.
- The consultant was not approached in time.
- This brings out the role of hierarchical culture and communication fragmentation as universal risks in healthcare systems.

2.4 Systemic Weaknesses Revealed

A number of systemic weaknesses are present in the case:

1. Communication Failures

- ✓ Poor communication between nurses and the junior doctors.
- ✓ Lack of structured escalation protocols.
- ✓ Failure to include parental concerns in clinical decision-making (Haskell, 2015).

2. Hierarchical Power Dynamics

- ✓ Junior doctors were not able or willing to contact senior clinicians.
- ✓ Unequal power distance ensured that it was difficult to voice out (Reason, 2000).
- ✓ Decision making was centralized on top levels hence delays.

3. Fragmented Care Delivery

- ✓ Several professionals engaged in the absence of coordinated control.
- ✓ Absence of continuity in patient monitoring.
- ✓ Execution of poor handover practices (CQC, 2022).

4. Unawareness of the Situation.

- ✓ Failure to recognize signs of deterioration.
- ✓ Cognitive biases, e.g. anchoring.
- ✓ This involves duties rather than patient-centered care (Endsley, 1995).

These flaws demonstrate the role of system design as opposed to individual incompetence in this result.

2.5 Level of Governance Influencing the Problem

Governance Level that is affecting the problem.

The malfunctions of this case cut across multiple governance levels:

1. Local Level

- Hospital Escalation and Supervision Policies.
- Staffing and work schedules.
- Ward culture and communication.

2. Regional Level

- Junior doctor training standards.
- However, hospital performance is monitored.

3. National Level

- Policies on patient safety and reporting.
- Legal regulations regarding clinical responsibility (NHS England, 2023).

The incident has been locally based but was influenced by national training infrastructures and other cultural norms in healthcare particularly in terms of hierarchy and communication.

2.6 Underlying System Challenges

The incident was caused by a number of challenges underlining it:

Workload and Staffing Pressure

- ✓ Junior physicians taking care of a number of patients with minimal supervision.
- ✓ qualities of decision-making (Carayon et al., 2014).

Training Gaps

- ✓ Lack of training on deterioration recognition of the patient.
- ✓ Lack of focus on communication and escalation skills.

Patient Safety Culture

- ✓ Lack of empowerment of nurses and families to voice concerns.
- ✓ Unsafe psychological conditions in groups (Edmondson, 1999).

Resource Constraints

- ✓ Pressures of time which prevent comprehensive evaluations.
- ✓ Competing clinical priorities.

These issues align with the global trends as determined by WHO and IHI, and this confirms that the case is one of the broader systemic problems in healthcare delivery.

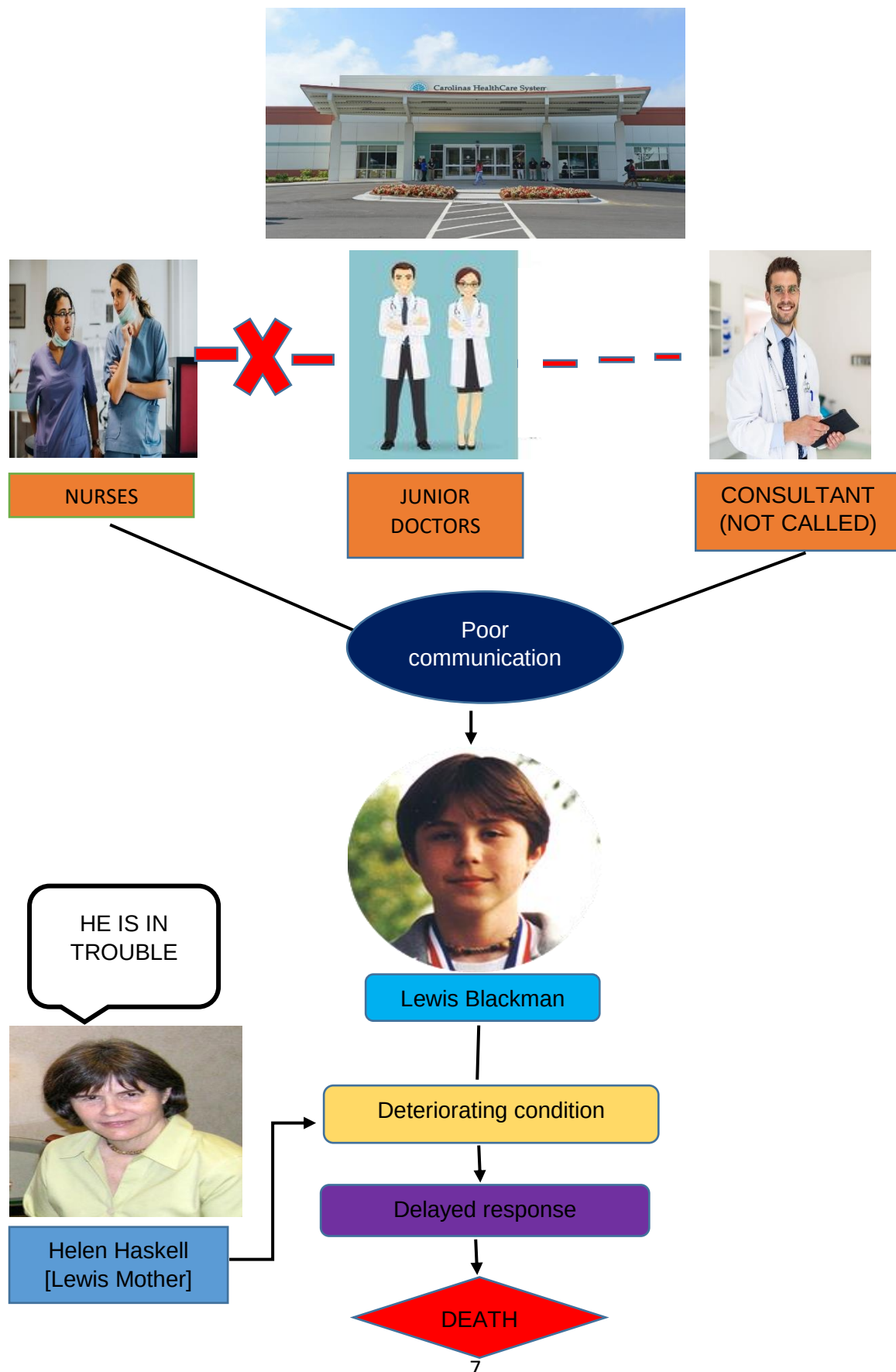
Setting the Agenda: Local and Global Importance.

The case of Lewis Blackman is not only of local importance but also of universal interest as it demonstrates:

- ✓ A particular failure in a single hospital system.
- ✓ A typical trend of avoidable injury in healthcare.

2.7 Rich Map

LEWIS BLACKMAN CASE OVERVIEW



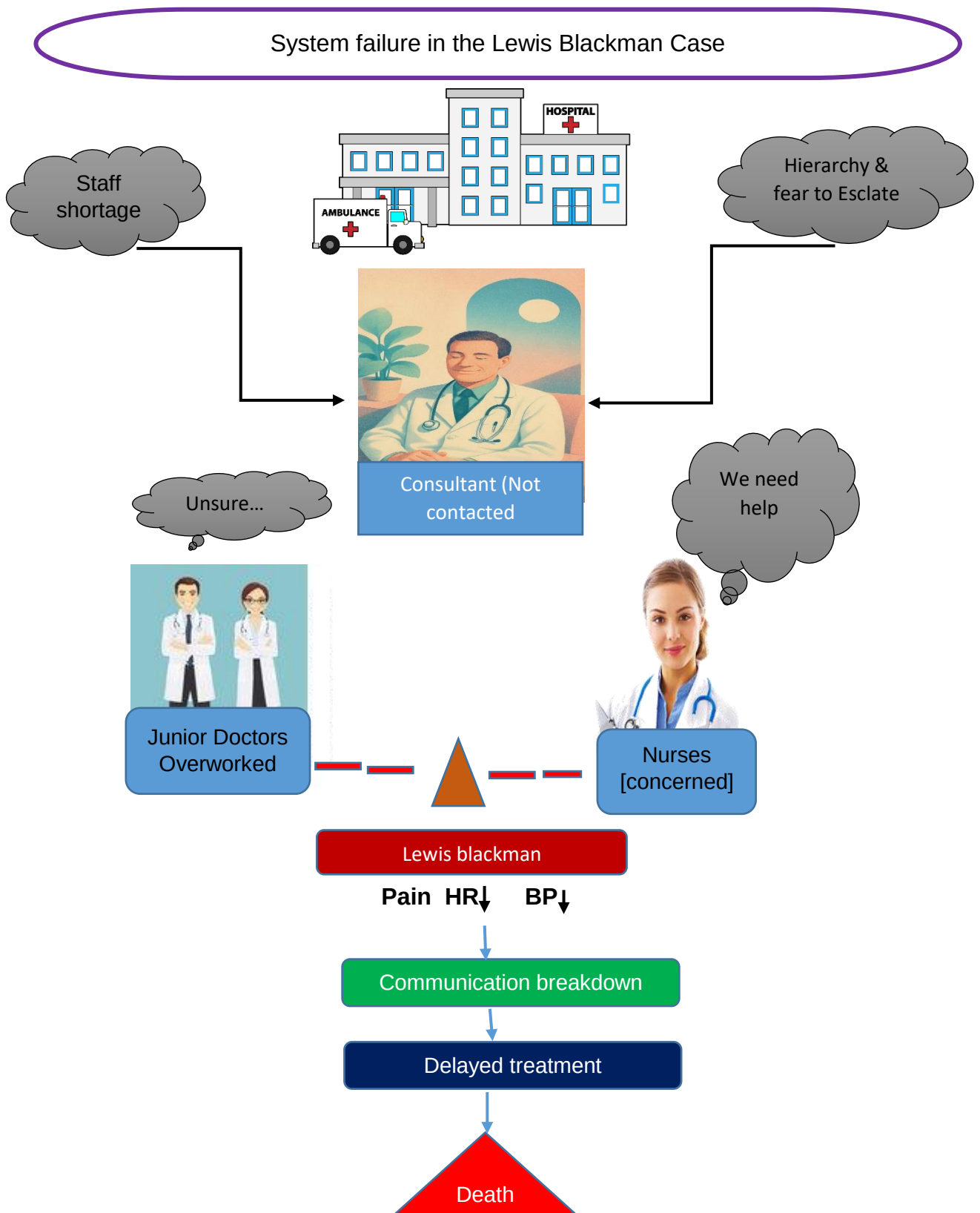


Figure 5 : System failure in the Lewis Blackman Case

3. Centralisation vs Decentralisation of case study

According to the case of Lewis Blackman, provided by Helen Haskell via the Patient Safety Movement Foundation, there was a breakdown in the areas of escalation, communication, and accountability, which is also a well-known phenomenon within the NHS England (Haskell, 2015; NHS England, 2023). This hybrid organisational design had a great impact on the decision-making and led to the low patient outcomes.

3.1 In Centralised system

Centralised system - This system has decision making power at a higher level of the organisation.

- ✓ Junior employees lack autonomy to a great extent [Weber, 1947].
- ✓ Escalation is based on the hierarchical approval [Weber, 1947].

In case study, the system is centralised

In the case of Lewis Blackman, junior doctors and nurses did not want to raise the issue without giving the direct mandate. This led to intensive delays in treatment. This was in the form of a rigid hierarchy coupled with the centralized structure making it difficult to make decisions promptly [Weber, 1947].

Evidence of Centralisation

In this instance, the aspects of centralisation were observed in the hierarchical medical authority:

- ✓ Nurses were submissive to doctors when the deterioration was evident.
- ✓ Increasing had to be physicians approved.
- ✓ Junior doctors were intermediaries to senior intervention.

This is similar to the NHS results where the escalation and decision-making can be procrastinated in case of poor communication and hierarchy management (NHS Resolution, 2022). ([NHS Resolution][1])

Supporting NHS Evidence

- NHS inquiries are showing that one of the most significant preventable factors of death is the inability to identify and intensify deterioration. ([NHS Resolution][1])
- Delays in treatment and diagnosis are also identified as important causes of preventable harm, as shown in national reviews. ([Parliamentary Ombudsman][2])

Impact

In Lewis's case:

- ✓ Vital signs (low urine output, tachycardia) were a sign of shock.
- ✓ Yet due to dependence on hierarchy escalation was postponed.

This is an indicator of problems throughout the NHS whereby inflexible structures delay response in emergencies.

Advantages to centralization, which are:

- ✓ Clear accountability [Weber, 1947]
- ✓ Standardized procedures [Weber, 1947]
- ✓ Less variation in care [Weber, 1947].

However, **the weaknesses** that have been witnessed in the case include:

- ✓ Late reaction to emergency cases [The King's Fund, 2014].
- ✓ Loss of empowerment of frontline employees [The King's Fund, 2014].
- ✓ Communication barrier as a result of hierarchy [The King's Fund, 2014].

On the other hand, decentralized system spreads the power among different levels, and it is possible to make faster decisions. As an example, nurses should have been empowered to mobilize rapid response teams so that they would intervene early enough [World Health Organization, 2007].

3.2 Decentralised Aspects in the Case Study

Decentralised model shares the responsibility with various staffs and teams.

Evidence of Decentralisation

- ✓ Various clinicians worked across shifts.
- ✓ No individual clinician was in charge.
- ✓ Team communication was not consistent.

This is indicative of the NHS system issues in inter-team or inter-organisational care coordination (Department of Health & Social Care, 2023). ([GOV.UK][3])

Supporting NHS Evidence

- ✓ Most NHS serious incident investigations have communication failures. ([NHS England][4])
- ✓ According to the statistics, communication is the most widespread reason of NHS complaints, and the number exceeds 33,000 cases each year. ([GOV.UK][3])
- ✓ Bad communication is a contributor to patient harm and treatment time lags. ([Healthwatch Data][5])

Impact

- ✓ Share of information between shifts was not effective.
- ✓ No comprehensive perception of the worsening of the patient.
- ✓ Responsibility became diffused.

Advantages:

- ✓ Quickening the responses to clinical deterioration [World Health Organisation, 2007].
- ✓ Higher empowerment of the staff [World Health Organisation, 2007].
- ✓ More with communication and cooperation [World Health Organisation, 2007].

Disadvantages

- ✓ Possible discrepancy in the generation of decisions [World Health Organisation, 2007].

- ✓ The need to train and coordinate more [World Health Organisation, 2007].

Critical Analysis

1. Crisis Management

The management of crisis needs swift escalation.

In this case:

- **Centralisation** → **delayed escalation**
- **Decentralisation** → **fragmented response**
 - **NHS Evidence**
 - ✓ About 11,000 preventable deaths in the UK annually are connected with a breakdown in systems (delays and lack of coordination). ([Parliamentary Ombudsman][2])
 - ✓ Poor communication is the cause of patient safety incidents in as many as 25 percent of cases. ([Yahoo News UK][6])
 - **Impact**
 - ✓ Lack of early recognition of the hypovolemic shock.
 - ✓ Delayed intervention
 - ✓ Preventable deterioration

2. Decision-Making

- ✓ Decision-making was limited as well as discontinuous:
- ✓ Nurses were not given the mandate to escalate on their own.
- ✓ Junior doctors used to determine decisions without the input of seniors.
- ✓ Information sharing was partial.
 - **NHS Evidence**
 - ✓ NHS reports identify as frequent causes of harm *diagnostic delays and errors. ([NHS Resolution][1])
 - ✓ Bad communication results in lost or late diagnoses and treatment. ([The Guardian][7])
 - **Impact**
 - ✓ Clinical deterioration was not taken seriously.
 - ✓ Decisions were made using incomplete information.

3. Accountability

Accountability was weakened due to decentralisation:

- ✓ No single practitioner in charge of general care.
- ✓ Responsibility spread across teams
 - **NHS Evidence**
 - ✓ NHS safety reviews recognize that one of the reasons behind avoidable deaths is due to poor and absent handovers and ownership ([Parliamentary Ombudsman][2]).
 - ✓ Reports indicate deficiency in lack of clear accountability in organisational boundaries. ([Patient Safety Commissioner][8])

- **Impact**

- ✓ Red flags were not taken into action.
- ✓ No responsibility to escalation was assumed.

- **Overall Evaluation**

The case presented in the table demonstrates systematic problems as are also found in the NHS:

FACTOR	CENTRALISATION WEAKNESS	DECENTRALIZATION WEAKNESS	SYSTEM OUTCOME
Escalation	Delayed approval	Unclear responsibility	Late intervention
Communication	Restricted upward flow	Fragmented across teams	Loss of Information
Accountability	Hierarchical gaps	Diffused ownership	No decisive action

Critical analysis proposes that hybrid approach can be the most effective one. Governance can be achieved through central supervision whereas frontline decision-making is quick. Healthcare systems evidence that the early warning system and rapid response teams can enhance patient outcomes by reducing the delays. In this case, the centralized framework impeded the crisis management as the pathways of escalation were ambiguous and dependent on the hierarchical endorsement. A decentralized system could have been more responsive and safer to patients [NHS England, 2020].

C. Leadership Theories and Application

Leadership was crucial in this case, especially in influencing communication, decision-making, and team dynamics [Northouse, 2021]. The case of *Lewis Blackman* showcases significant failures in leadership, communication, and patient safety in a healthcare setting. Examining this case through established leadership theories reveals how leadership styles affected decision-making, staff behavior, and, ultimately, patient outcomes. This discussion focuses on three key leadership approaches: transformational leadership, transactional leadership, and distributed (shared) leadership. It evaluates their effectiveness using evidence like safety outcomes, staff dynamics, and organizational culture (Wong et al., 2013; Clarke, 2013; West et al., 2014).

1. Transformational Leadership

Transformational leadership aims to inspire and motivate staff toward a common vision while promoting open communication and focusing on patient-centered care. Leaders who use this approach encourage critical thinking, psychological safety, and ongoing improvement (Bass & Riggio, 2006; West et al., 2015).

In the Lewis Blackman case, there is little evidence of transformational leadership. The healthcare team did not create an environment where junior staff felt encouraged to question

decisions or raise concerns. For instance, despite clear signs of patient deterioration, like severe abdominal pain and abnormal vital signs, nurses and junior doctors did not effectively challenge assumptions or strongly advocate for intervention. This shows a lack of psychological safety, a key component of transformational leadership (Edmondson, 1999; Nembhard & Edmondson, 2006).

Data indicates that hospitals with higher levels of transformational leadership report better safety outcomes, including lower mortality rates and fewer adverse events (Wong & Cummings, 2007; Boamah et al., 2018). Surveys in these environments often reflect higher trust, better communication, and a greater willingness to report concerns. In contrast, the Blackman case highlights low staff empowerment and poor communication—signs of weak transformational leadership (West et al., 2015).

The lack of this leadership style contributed to a culture where cognitive biases, such as normalisation of deviance and anchoring, were left unchallenged. A transformational leader could have encouraged reflective practice and questioning, which might have prevented the series of errors that followed (Reason, 2000; Croskerry, 2003).

Transformational Leadership focuses on inspiring and motivating staff to meet high standards. In this case, the lack of transformational leadership led to a missing shared vision for patient safety. Leaders did not create an environment where staff felt empowered to raise concerns [Bass & Avolio, 1994].

2. Transactional Leadership

Transactional leadership is grounded in clear roles, hierarchies, and compliance with established procedures. It relies on rewards and penalties to manage performance and can be effective in high-risk environments that need standardization (Bass & Riggio, 2006).

In this case, elements of transactional leadership were present but not effectively implemented. The hospital had a hierarchical structure where junior staff deferred to senior clinicians. However, this rigidity led to communication issues. Nurses tried repeatedly to reach senior doctors but were often ignored or dismissed, pointing to failures in escalation protocols (Institute of Medicine, 2000; Joint Commission, 2015).

Safety data in healthcare shows that overly rigid transactional systems can hinder communication, especially when staff fear negative consequences for speaking up. Research indicates that communication failures are a major cause of preventable harm, contributing to a substantial number of sentinel events (The Joint Commission, 2015; WHO, 2009).

The leadership approach in this case seemed reactive and command-driven rather than proactive. Staff followed existing routines and assumptions instead of re-evaluating the patient's condition. While transactional leadership can provide consistency, relying on it too heavily without supportive communication methods can stifle critical thinking (Goleman, 2000).

A more effective approach would have included clear pathways for escalation, accountability structures, and reinforcement of safety protocols, backed by measurable indicators like response times to clinical issues and adherence to early warning systems (NICE, 2007; Royal College of Physicians, 2012).

Transactional Leadership emphasizes structured processes and adherence to rules. While necessary for maintaining standards, too much reliance on transactional leadership can stifle critical thinking. In this case, staff followed routines without adapting to patient deterioration [Burns, 1978].

3. Distributed (Shared) Leadership

Distributed leadership focuses on shared responsibility, collaboration, and collective decision-making among all staff levels. This approach is especially important in complex healthcare settings where input from multiple disciplines is essential (Spillane, 2006; West et al., 2014).

The shortcomings of distributed leadership are evident throughout this case. Care delivery was disjointed, with poor coordination between nurses, junior doctors, and consultants. Each group worked in isolation, which led to communication gaps and delays in decision-making (Manser, 2009).

Evidence shows that distributed leadership boosts team performance, improves communication, and decreases medical errors (West et al., 2014; Salas et al., 2008). Engagement data frequently shows higher job satisfaction and stronger teamwork in organizations using this model. Conversely, the Blackman case indicates low collaboration and ineffective teamwork, both of which contributed to the negative outcome (Manser, 2009).

The absence of shared leadership highlights problematic power dynamics, as junior staff felt unable to challenge senior authority. Research suggests that hierarchical cultures can discourage staff from speaking up, especially in high-stress environments (Edmondson, 2003; Morrison, 2014).

A distributed leadership model could have allowed for earlier intervention. For example, empowering nurses to voice concerns independently or start rapid response protocols might have changed the outcome. The failure to implement leadership structures that prioritize patient safety over hierarchy is evident (Jones et al., 2011).

➤ Emotional Intelligence and Leadership Effectiveness

Another angle for analysis is emotionally intelligent leadership, which involves self-awareness, empathy, and effective communication (Goleman, 1998). In this case, there is limited evidence of emotional intelligence among leaders. Staff did not seem to grasp the urgency of the situation or respond empathetically to the concerns of the patient and family (Codier et al., 2010).

Patient safety data increasingly connects emotional intelligence with better clinical outcomes and fewer complaints. Leaders who show empathy and practice active listening build trust and promote open communication (Freshman & Rubino, 2002; Codier et al., 2010). The dismissive responses seen in this case indicate a lack of these skills (Goleman, 2000).

➤ **Evaluation of Leadership Effectiveness**

Overall, the leadership displayed in the Lewis Blackman case was *ineffective and ill-suited for the situation. It tended to be reactive, hierarchical, and focused on tasks rather than proactive, collaborative, and patient-centered *(West et al., 2015).

Key signs of poor leadership effectiveness include:

Negative safety outcomes: The ultimate failure—preventable patient death—reflects systemic issues (Institute of Medicine, 2000).

- ✓ **Communication failures:** Multiple missed chances to escalate care (Joint Commission, 2015).
- ✓ **Low staff empowerment:** Junior staff felt unable to question decisions (Edmondson, 1999).
- ✓ **Fragmented care delivery:** Lack of coordination across teams (Manser, 2009).

These outcomes align with broader healthcare data that links poor leadership to higher rates of adverse events, lower staff engagement, and reduced quality of care (West et al., 2015; WHO, 2009).

➤ **What Could Have Been Done Differently?**

A more effective leadership approach would have combined aspects of transformational, distributed, and emotionally intelligent leadership:

Fostering a speak-up culture: Encouraging staff to voice concerns without fear of retribution (Edmondson, 1999).

Implementing proactive safety systems: Such as early warning scores and rapid response teams (Royal College of Physicians, 2012).

Improving communication training: Utilizing structured tools like SBAR *(WHO, 2009).

Developing emotional intelligence: Training leaders to respond empathetically and recognize clinical urgency (Goleman, 1998).

Adopting distributed leadership: Empowering teams across disciplines to collaborate and share responsibility (West et al., 2014).

These strategies are backed by evidence that shows improvements in patient safety, staff satisfaction, and overall organizational performance (Boamah et al., 2018; West et al., 2015).

Situational Leadership involves adjusting leadership styles based on the context. This approach would have been suitable since clinical deterioration requires quick and flexible

decision-making. However, leaders did not adapt, which led to delayed action [Hersey & Blanchard, 1969].

➤ **Key leadership failures include:**

- ✚ Lack of proactive decision-making [Care Quality Commission, 2018]
- ✚ Poor communication and team coordination [Care Quality Commission, 2018]
- ✚ Inadequate escalation of concerns [Care Quality Commission, 2018]
- ✚ Insufficient supervision of junior staff [Care Quality Commission, 2018]

Leadership effectiveness can also be measured through data, such as patient outcomes and incident reports. In this case, the outcome clearly indicates a failure in leadership [Care Quality Commission, 2018].

An alternative approach could involve emotionally intelligent leadership, where leaders recognize concerns, encourage open communication, and take proactive steps. Distributed leadership, where responsibilities are shared across the team, might also improve outcomes [Goleman, 1998].

d. Improvement and Lessons Learned

The situation with Lewis Blackman demonstrates that leadership and governance failures may have a direct adverse effect on patient safety. His death was not caused by a single clinical error, but the overall flaws in the system due to rigid hierarchies, poor leadership, and absence of accountability. Despite the fact that governance structures were in place, they could not be effective due to the leadership practices that hindered communication, slowed down the need to do things, and provided ambiguity in responsibilities. This is in line with the systemic failure model that is explained by James Reason (Reason, 2000), which explains how various latent conditions lead to injury.

Problem 1 Delayed escalation because of hierarchical culture.

Problem: There was a strict, centralised hierarchy that was a barrier to timely escalation of care. Junior employees observed that Lewis was in a deteriorating state but they were unable to express their issues to the senior clinicians. Its leadership was to a great extent authoritarian, situating more importance on status rather than collaboration and restricting the psychological safety.

Data: It has been found that a low safety culture and rigid hierarchies have a close connection with adverse results. According to the work of Amy Edmondson, the deficit of psychological safety reduces the desire of staff to voice worries, which adds more risks to the damages (Edmondson, 1999; Nembhard and Edmondson, 2006). Failure to intervene on deterioration by promptly identifying and acting on it has also been found to be a major contributor to preventable deaths as noted by national audits (National Patient Safety Agency, 2007), and it has been revealed that this is a recurrent problem.

Improvement: This problem can be solved by introducing digital early warning systems (EWS) and making it mandatory to escalate the situation. The objective physiological data is used to issue alerts in these systems to minimize the use of subjective judgments (Royal College of Physicians, 2017). Meanwhile, hierarchies and the lack of open communication may be minimized through Crew Resource Management (CRM) training (Salas et al., 2006).

Evaluation: Although EWS can be useful to improve the detection of deterioration, they will not be successful unless the organizational culture works. Even alerts can be disregarded or postponed in case leadership is not devoted to the development of psychological safety. As such, the leadership behaviors should support the governance protocols and systems by empowering the staff. There should be a change towards transformational leadership to foster the culture of expecting escalation instead of deterring it (Francis, 2013).

Problem 2: Disjointed care and poor accountability

Problem: Care delivery was disintegrated with the involvement of various clinicians without a single lead to the overall condition of Lewis. Governance was unable to create clarity of accountability, and there was a gap in the monitoring process and intervention.

Data: The research on handover failures demonstrates that the lack of effective communication during care transfer increases the risk of medical errors and adverse events greatly (Arora et al., 2005; Starmer et al., 2014). The studies have shown that organized handovers can minimize the error up to 30 per cent, highlighting the risks of disorganized care.

Improvement: It is recommended that governance must require: An appointed lead clinician to each patient, Standardised communication (SBAR) (Situation, Background, Assessment, Recommendation) (Haig et al., 2006), Strict and recorded handover procedures. Such actions would assist in enhancing continuity of care and creating a better accountability between teams (Department of Health, 2010).

Evaluation: These governance tools explain what is required but the success of the tools will rely on the enforcement and involvement of leadership. Unless leaders are focused on compliance or create a good example of communication, procedures can be symbolic and not effective. Therefore, accountability measures should also be regularly checked and reinforced by the leadership.

Problem 3: Cognitive biases in clinical decision-making

Problem: There was a cognitive bias in clinical decision-making, anchoring and normalization of deviance. Clinicians did not consider the severity of the conditions of Lewis, and they did not re-evaluate when new symptoms manifested themselves.

Data: According to the studies by Daniel Kahneman, the cognitive bias has a systematic effect on making decisions during uncertainty (Tversky and Kahneman, 1974). These biases play a major role in causing diagnostic errors in healthcare, which is one of the primary sources of avoidable harm (Crookery, 2003; Graber et al., 2012).

Improvement: The improvement to be done by governance is: Clinical decision-support tools and clinical checklists. Mandatory second opinions in the high-risk cases. Regular multidisciplinary reviews. Such steps reduce the reliance on individual judgment and promote the use of evidence to make decisions.

Evaluation: DSS tools have the potential to decrease bias, although overreliance on them can cause inflexibility. It needs to be well-led so as to balance the implementation of protocols and clinical judgment. Leaders are also supposed to encourage reflective practice where the clinicians are supposed to question what they assume and learn through mistakes.

Problem 4: The inability to consider patient and family feedback

Problem: The concerns brought up by the mother of Lewis were not addressed. This is an indication of the breakdown in governance and leadership to consider patients and their families as key partners of care.

Data: The studies have shown that patient and family involvement can be beneficial in terms of early identification of deterioration and improved outcomes on patient safety (Berwick, 2009). The family is usually aware of minor changes that a clinical staff may not be in a position to detect.

Improvement: The healthcare organizations should:

- ☐ Institute family escalation measures.
- ☐ Promote free communication policies.
- ☐ Foster shared decision-making

Evaluation: In as much as engaging the patients enhances safety, it necessitates cultural change. The leadership needs to authenticate family issues and make the staff perceive them as a valuable contribution and not as a threat to leadership. Leadership-governance-system structure interaction.

The mistakes in this occasion were interrelated. A centralized system had concentrated decision-making authority with the senior clinicians, and the frontline staff was not allowed to make decisions. The authoritarian type of leadership supported this structure and killed communication and concerns. In the meantime, systems of governance did not have effective feedback systems, that is, mistakes were not recognized and corrected.

However, a more decentralized system that involves inclusive and transformational leadership would allow responding faster, distributing responsibilities, and communicating more effectively. Such tools as early warning systems, structured handovers, and audit processes would probably be more efficient within such an environment due to the feeling of empowerment on the part of staff members (Wears and Sutcliffe, 2015).

➤ **Role of feedback systems and continuous improvement**

- ☐ Feedback systems and constant improvement role.

Another important aspect that was lacking in this case was the effective feedback. Audit systems and real-time monitoring as well as incident reporting were either ineffective or not employed. James Reason said that the resilient systems should be based on the ability to learn a lesson about the near misses and change accordingly (Reason, 2000).

It is indicated that organisations that have a well-developed audit and feedback system are able to sustain patient safety improvements (Ivers et al., 2012). The periodic inspection of the negative incidents, combined with open reporting, assists organisations in identifying trends, working on the areas of weaknesses, and enhancing the responsibility.

Lessons on healthcare organisations.

In this case, the following lessons can be brought out:

1. Culture is influenced by leaders: Psychological safety plays an important role in effective communication and escalation (Edmondson, 1999).
2. Accountability in governance: Roles and structure of communication, continuity of care are important (Department of Health, 2010).
3. The design of the system is important: Team based systems that are decentralised are more responsive to the system structure compared to the strict hierarchies.
4. Information has to be the motivator towards change: Learning and adjustments are imperative to continuous monitoring, audits, and feedback (Ivers et al., 2012).
5. Patients are safety partners: It is another way to provide an extra insurance against failure by involving families (Berwick, 2009).
6. Systems Integration: Early detection can be done with digital monitoring systems [World Health Organization, 2021], The coordination between departments can be improved [World Health Organization, 2021].

➤ **Lessons learned include:**

There is interconnection between leadership, governance and system design.

Hierarchy is a possible source of damage to patient safety.

It is critical to have constant learning and feedback.

6. Recommendation

Lewis Blackman case demonstrates great weaknesses in the leadership, governance, and system design. Healthcare organizations must implement evidence-based changes, which are integrated to address structural and cultural problems to prevent similar events.

1. Leadership of the Sustained Improvement

Transformational and distributed leadership would be an ideal mix of leadership styles that can be applied in this organization. Transformation leadership promotes a vision, free communication, and safety culture, which is crucial in the improvement of psychological safety (Francis, 2013). Conversely, distributed leadership enables the staff in the frontline to make decisions and act fast in cases whereby patient deterioration is observed.

A study conducted by Amy Edmondson has shown that psychologically safe environments enhance performance of the team, and reduce errors (Edmondson, 1999). The leaders have to promote employees to be open and confront the hierarchical barriers, demonstrate transparency, and accountability.

2. Strengthening Governance Structures

Governance should not be limited to the presence of policies in order to achieve successful implementation. Key actions include:

Scoring 122, 1 indicates that assigning a named lead clinician to each patient is the assigned score.

- ☐ Setting up of clear cut escalation measures with stipulated time-frames to respond.
- Embedding clinical accountability frameworks in the day-to-day practice.

This is in line with the ideas of Robert Francis report that focuses on the accountability and patient-centred care (Francis, 2013).

Review of governance, which is facilitated by audit and performance data, should also be done regularly in order to ensure compliance and identification of gaps in care delivery.

3. Implement a System Structure of Hybrid.

Decentralize the decision-making process and have central governance [The King's Fund, 2014].

4. Enhancing Systems Integration and Improvement of Communication

The main aspect of this case was communication failure. Organizations should:

- ☐ Make structural communication instruments such as SBAR.
- ☐ Install the electronic health records (EHRs) of real-time information sharing.
- ☐ Standardize departments handover procedures.

It has been demonstrated that the systematic communication will help to minimize the number of errors and improve patient outcomes (Starmer et al., 2014). The inclusion of digital systems would make sure that the patient-related information is always accessible and responded to.

5. On-going Learning and Feedback Systems

The organizations need to instill continuous learning by:

Incident reporting systems- adverse events and near misses.

- ☐ Periodic reviews of multidisciplinary morbidity and mortality.
- ☐ Audit and feedback to check improvement and performance.

James Reason observes that organizations with high reliability keep learning all the time through failure (Reason, 2000). It has been demonstrated that feedback systems enhance the compliance and patient safety outcomes (Ivers et al., 2012).

The sixth innovation is Stakeholder Engagement and Co-production.

Patients and families are expected to be considered as active care participants. This would be possible through:

- ☐ The pathways of family escalation introduction.
- ☐ Encouraging shared decision-making

KEY -Inclusion of patients and families in service design and safety committees.

The studies have shown that patient participation improves safety as it helps to identify the potential signs of deterioration (Berwick, 2009). In this situation, failure to intervene on the issue of concern by parents translated to a lost opportunity to avoid injury.

7. Improving the Technical and Allocative Efficiency

The enhancement of efficiency will need the utilization of clinical resources and organizational processes in a more efficient way:

- ☐ Technical efficiency:
- ☐ Adopt digital early warning systems in order to enhance the deterioration detection.
- ☐ Standardize the protocols to reduce the variation of care.

Minimize duplicate by having combined systems.

Allocative efficiency:

Make sure that there is proper staffing and the skill mix.

- ☐ Invest in risky regions such as the post-operative care.
- ☐ Major in investment in safety-critical technologies.

There is an indication that the use of early warning systems and standard care pathways reduces mortality and improves the utilization of resources (Royal College of Physicians, 2017).

8. Installing Early Warning Systems.

- ✓ Detect and report clinical deterioration [Royal College of Physicians, 2017].

9. Promote a Culture of Safety.

- ✓ Provide the atmosphere in which employees are not afraid of expressing their concerns [Institute of Medicine, 2000].

The recommendations are evidence-based and are in line with the universal best practices in healthcare systems.

➤ Conclusion

The Lewis Blackman case is a powerful example of how failures in leadership, governance, and system design can result in preventable patient harm. This analysis shows that his death stemmed from multiple system failures rather than a single clinical mistake. A rigid hierarchical structure and authoritarian leadership created an environment where staff felt unable to raise concerns. Meanwhile, fragmented care delivery and weak governance led to unclear accountability and delayed intervention.

This case emphasizes the importance of psychological safety, as noted by Amy Edmondson, in allowing effective communication and teamwork. It also highlights James Reason's systems-based approach, which underscores how hidden organizational weaknesses contribute to negative events. Without effective feedback systems, opportunities for learning and improvement were lost, further compounding the failures.

To tackle these issues, healthcare organizations must take a systems-thinking approach that integrates leadership, governance, and data-driven improvement. Transformational and distributed leadership styles are crucial for promoting a culture of openness and accountability. Governance frameworks should clarify roles, enable structured communication, and support continuous performance monitoring. Additionally, using digital tools like early warning systems can aid timely clinical decision-making and lessen reliance on individual judgment.

Ultimately, this case shows that patient safety relies on more than clinical skills; it demands well-designed systems, supportive leadership, and a culture that values learning and collaboration. By incorporating these principles into practice, healthcare organizations can boost safety, improve efficiency, and prevent similar tragedies in the future.

7. REFERENCE

Care Quality Commission (2024). *The state of health care and adult social care in England 2024/25* - Care Quality Commission. [online] Cqc.org.uk. Available at: <https://www.cqc.org.uk/publications/major-report/state-care/2024-2025>.

Collins, J. (2026). *Auto Draft*. [online] McCollum Consultants. Available at: <https://www.mccollumconsultants.com/article/nhs-england-never-events-2025-data/> [Accessed 1 Apr. 2026].

connor (2025). *NHS Negligence Claims Payouts Statistics*. [online] NHS Negligence. Available at: <https://nhsnegligence.co.uk/nhs-negligence-claims-payouts/>.

Gadsby Wicks (2024). *NHS Medical Negligence Claims Statistics 2024/2025: National & Essex Data*. [online] Gadsby Wicks. Available at: <https://www.gadsbywicks.co.uk/insights/medical-negligence/nhs-medical-negligence-claims-statistics>.

Hughes, A. (2025). *Clinical Negligence Statistics 2025*. [online] Jmw.co.uk. Available at: <https://www.jmw.co.uk/articles/clinical-negligence/clinical-negligence-statistics-2025>.

Institute of Medicine (2000). *To err is human: Building a safer health system*. [online] Washington, D.C.: National Academies Press. doi:<https://doi.org/10.17226/9728>.

NHS England (n.d.). *NHS England» Governance*. [online] www.england.nhs.uk. Available at: <https://www.england.nhs.uk/cancer/quarterly-report-overviews/q4-2021-q1-2122/governance/>.

NHS Leadership Academy (2021). *Healthcare Leadership Model – Leadership Academy*. [online] www.leadershipacademy.nhs.uk. Available at: <https://www.leadershipacademy.nhs.uk/healthcare-leadership-model/>.

Patient Safety Movement (2014). *Lewis Blackman - Psmf.org*. [online] Patient Safety Movement. Available at: <https://psmf.org/story/lewis-blackman/>.

Research and Markets (2025). *UK Clinical Negligence Market Report 2025 | Claims Going to Trial or Proceedings Fall for the Fourth Year Running*. [online] GlobeNewswire News Room. Available at: <https://www.globenewswire.com/news-release/2025/09/15/3149725/0/en/UK-Clinical-Negligence-Market-Report-2025-Claims-Going-to-Trial-or-Proceedings-Fall-for-the-Fourth-Year-Running.html> [Accessed 1 Apr. 2026].

Tom Treasure Professor in Cardiothoracic Surgery, St George's Hospital, London, UK (2026). *Improving surgical care: looking beyond individual competence*. [online] Bmj.com. Available at: <https://qualitysafety.bmj.com/content/9/1/2> [Accessed 1 Apr. 2026].

Verified Market Reports (2026). *Medical Malpractice Insurance Market Forecast United States 2025 | Industry Growth & Analysis*. [online] Verified Market Reports. Available at: <https://www.verifiedmarketreports.com/product/medical-malpractice-insurance-market-size-and-forecast/> [Accessed 1 Apr. 2026].

World Health Organisation (2021). *Global Patient Safety Action Plan 2021-2030*. [online] www.who.int. Available at: <https://www.who.int/publications/i/item/9789240032705>.

World Health Organization (2023). *Patient safety*. [online] World Health Organization. Available at: <https://www.who.int/news-room/fact-sheets/detail/patient-safety>.

Archives, T.N. (n.d.). *The National Archives*. [online] UK Government Web Archive. Available at: <https://www.nationalarchives.gov.uk/webarchive/>.

Berwick, D.M. (2009). What 'Patient-Centered' Should Mean: Confessions Of An Extremist. *Health Affairs*, 28(Supplement 1), pp.w555–w565. doi:<https://doi.org/10.1377/hlthaff.28.4.w555>.

Edmondson, A. (1999). Psychological Safety and Learning Behavior in Work Teams. *Administrative Science Quarterly*, 44(2), pp.350–383. doi:<https://doi.org/10.2307/2666999>.

Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. [online] GOV.UK. Available at: <https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry>.

Goleman, D. (2000). *Leadership That Gets Results*. [online] Harvard Business Review. Available at: <https://hbr.org/2000/03/leadership-that-gets-results>.

Joint Commission international (2025). *Sentinel Event Policy*. [online] Jointcommission.org. Available at: <https://www.jointcommission.org/en/knowledge-library/sentinel-events>.

Kahneman, D. and Tversky, A. (1979). Prospect theory: an Analysis of Decision Under Risk. *Econometrica*, 47(2), pp.263–292. doi:<https://doi.org/10.2307/1914185>.

Linda T. Kohn, Janet M. Corrigan National Academies of Sciences, Engineering, and Medicine. 2000. *To Err Is Human: Building a Safer Health System*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/60>. (2025). *To Err Is Human* . *Nationalacademies.org*. [online] doi:<https://doi.org/10.17226/9728>.

Macario, A., Schilling, P., Rubio, R., Bhalla, A. and Goodman, S. (2003). What questions do patients undergoing lower extremity joint replacement surgery have? *BMC Health Services Research*, [online] 3(1). doi:<https://doi.org/10.1186/1472-6963-3-11>.

MARCXML (2015). *The theory of social and economic organization : Weber, Max, 1864-1920 : Free Download, Borrow, and Streaming : Internet Archive*. [online] Internet Archive. Available at: <https://archive.org/details/theoryofsocialec00webe>.

Nembhard, I.M. and Edmondson, A.C. (2006). Making It safe: the Effects of Leader Inclusiveness and Professional Status on Psychological Safety and Improvement Efforts in Health Care Teams. *Journal of Organizational Behavior*, 27(7), pp.941–966. doi:<https://doi.org/10.1002/job.413>.

NHS (n.d.). *Annual statistics*. [online] NHS Resolution. Available at: <https://resolution.nhs.uk/resources/annual-report-statistics/>.

NHS England (2022). *Patient Safety*. [online] England.nhs.uk. Available at: <https://www.england.nhs.uk/patient-safety/>.

NHS Leadership Academy (2021). *Healthcare Leadership Model – Leadership Academy*. [online] www.leadershipacademy.nhs.uk. Available at: <https://www.leadershipacademy.nhs.uk/healthcare-leadership-model/>.

OUP Academic. (2025). *Academic Medicine*. [online] Available at: <https://academic.oup.com/academicmedicine?login=false>.

Rcplondon.ac.uk. (2017). *National Early Warning Score (NEWS) 2*. [online] Available at: <https://www.rcplondon.ac.uk/resources/national-early-warning-score-news-2/>.

Reason, J. (2000). Human Error: Models and Management. *British Medical Journal*, 320(7237), pp.768–770. doi:<https://doi.org/10.1136/bmj.320.7237.768>.

Starmer, A.J., Spector, N.D., Srivastava, R., West, D.C., Rosenbluth, G., Allen, A.D., Noble, E.L., Tse, L.L., Dalal, A.K., Keohane, C.A., Lipsitz, S.R., Rothschild, J.M., Wien, M.F., Yoon, C.S., Zigmont, K.R., Wilson, K.M., O’Toole, J.K., Solan, L.G., Aylor, M. and Bismilla, Z. (2014). Changes in Medical Errors after Implementation of a Handoff Program. *New England Journal of Medicine*, [online] 371(19), pp.1803–1812. doi:<https://doi.org/10.1056/nejmsa1405556>.

Talbert, S. and Talbert, D. (2026). Developing a Methodology to Improve the Allocation of Specialized Health Resources for Acutely Injured Persons. *AMIA Annual Symposium Proceedings*, [online] 2003, p.1025. Available at: <https://pmc.ncbi.nlm.nih.gov/articles/PMC1480243/> [Accessed 8 Apr. 2026].

- Tong, A., Sainsbury, P. and Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, [online] 19(6), pp.349–357. doi:<https://doi.org/10.1093/intqhc/mzm042>.
- Tversky, A. and Kahneman, D. (1974). Judgment under uncertainty: Heuristics and Biases. *Science*, 185(4157), pp.1124–1131.
- West, M., Armit, K., Loewenthal, L., Eckert, R., West, T. and Lee, A. (2015). *Leadership and Leadership Development in Health Care*. [online] The King's Fund. Available at: <https://www.kingsfund.org.uk/insight-and-analysis/reports/leadership-development-health-care>.
- WHO (2022). *Medication without harm*. [online] World Health Organization. Available at: <https://www.who.int/initiatives/medication-without-harm>.
- WONG, C.A. and CUMMINGS, G.G. (2007). The relationship between nursing leadership and patient outcomes: a systematic review. *Journal of Nursing Management*, [online] 15(5), pp.508–521. doi:<https://doi.org/10.1111/j.1365-2834.2007.00723.x>.
- World Health Organization (2023). *Patient safety*. [online] World Health Organization. Available at: <https://www.who.int/news-room/fact-sheets/detail/patient-safety>.