Witness Statement of Louis Patrick Lillywhite

1. I am Lieutenant-General (Retired) Louis Patrick Lillywhite, a Registered Medical Practitioner with a licence to practice. I have prepared this statement to assist The Iraq Inquiry in advance of my evidence session on 20 July 2010.

2. I attach directly to this statement (behinds tabs numbered (1)-(8)) the following eight documents:[II1]

   (1) Director General Medical Operational Capability Report;
   (2) DMS Top Structures – Next Steps Project (Final Paper – 5 Aug 2007)
   (3) Extract from Hansard: 16 July 2008 – Midland Medical Accommodation
   (4) D/DGAMS/1/1 dated 2 Aug 04
   (5) Healthcare Commission: Defence Medical Services - A review of the clinical governance of the Defence Medical Services in the UK and overseas (March 2009)
   (6) National Audit Office: Ministry of Defence - Treating Injury and Illness arising on Military Operations (10 February 2010)
   (7) House of Commons Defence Committee: Medical Care for the Armed Forces (Seventh Report of Session 2007-08). Printed 5 February 2008
   (8) The Nation's Commitment: Cross-Government Support to our Armed Forces, their Families and Veterans (July 2008)

3. Over the initial period of operations in Iraq I was Director (Chief Executive) of British Forces Germany Health Service during which time I had no responsibility for operations in Iraq.

4. On 4th May 2003 I was appointed Director General Army Medical Services (DGAMS) in the rank of Major-General, moving to Director-General Medical Operational Capability (DG Med Op Cap), in July 2005 and then on 28 October 2006 assumed the role of Surgeon-General (SG), handing over to my

II1: The Iraq Inquiry has received copies of these documents. Document (1) has been declassified and published on our website. Documents (2) and (4) are internal MOD documents and are not being published by the Inquiry. All other documents are available on the internet.

successor on 19 December 2009. In these 3 roles I had either responsibilities or a role in respect of operations in Iraq. As DGAMS I was responsible for providing assurance that the Army medical units that deployed to Iraq were fit for role. As a consequence of a variety of issues that arose in this role, which I will describe below, I was asked to undertake a review of the operational capability of the Defence Medical Services in the newly created appointment as DG Med Op Cap. I was then appointed as SG and as a result both of the DG Med Op Cap Study and another study: "*Top Structures- Next Steps*", my role changed during my tenure, influenced by ongoing operations, which I shall also explain below.

5. However, before turning to the specific issues of Iraq it is necessary to place these in the broader context of the developments in the Defence Medical Services (DMS). At the end of the Cold War, the 3 medical services (RN, Army, RAF) were largely separate with their main roles being to provide medical care and evacuation to their own Services. The RAF provided peacetime aero-medical evacuation, but in the event of war in Europe it was planned that casualties would return to the UK by rail and ferry. The Army's medical services, which provided the bulk of hospitals, was optimised for the large numbers of casualties that were expected to arise from a war in NW Europe. The emphasis was thus on quantity with compromise in respect of quality. Thus, for example, dental officers were trained to act as auxiliary anaesthetists and casualties on admission to hospitals would be triaged by either junior doctors or nurses. A high mortality rate was expected, 40% being the planning figure, but as it was expected that the UK mainland would also be involved in the war it was considered that the compromises were reasonable. It was this medical service that deployed in the first Gulf War, where as events turned out, casualty rates were much lower than expected. Casualty rates remained low (compared to historic rates) in subsequent operations and the DMS has evolved into a low quantity high quality system and for example casualties on admission to a field hospital will now be received by a team of Consultants instead of a junior doctor or nurse.

6. This process has been accelerated by the introduction into the UK of Clinical Governance. Individual health professionals were exposed to this in their civilian practice and took the initiative of seeking to introduce it within the units to which they deployed on operations. Subsequently, as a result of operations in Iraq (see below) this has been regularised and systemised.

7. I will now turn to my roles. Prior to becoming DGAMS, my responsibilities for healthcare in Germany had exposed me to Clinical Governance processes (which in essence are Quality Assurance processes) in primary and hospital care, and in particular the contract with Guys and St Thomas' NHS Trust had led to the quality of hospital healthcare in Germany being given very high priority. On assuming my role as DGAMS, I gave priority to introducing similar processes across the AMS, including the operational domain where they had before never formally existed. Meeting returning units, reading post-deployment reports of those units and visiting Iraq indicated that at the individual level, quality assurance was being introduced, but it varied with individual clinicians and with different units and was not uniform. By the end of the first year as DGAMS I formally reported in my *First Year Report*"[1] that:

> "There are 2 aspects to the AMS's operational role: the 'physical' and the 'moral'. The physical part is ensuring that the right resources are in the right place at the right time, capable of surviving and communicating in the land environment, and able to clear casualties in order that operational commanders are not constrained. The 'moral' element is the provision of clinical excellence to ensure survival of the maximum number, and to minimise subsequent disability in order to contribute to the Covenant between the Army and its personnel.
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> a. Physical Component. I judge the physical component to be robust and generally of high standard. Future Army Structures offers the opportunity to remove the difficulties associated with the cadreisation of our CS Medical Regiments. Re-subordination of 5 GS to 102 Log Bde will lead to a better balance of support in the rear area, and the overall re-configuration of the AMS will permit us to achieve the required harmony against current DPAs. Like other parts of the Army's ORBAT, we continue to carry risk. In our case it will be at large scale when we place reliance on two small TA Medical Regiments for the evacuation from CS Medical Regiments to forward Field Hospitals. Doctrine is either up-to-date or being staffed. Medical commanders are militarily well trained and deployable units and sub-units are

[1] D/DGAMS/1/1 dated 2 Aug 04

militarily capable. Regular Field Hospitals do lack rapid deployability and their ability to manoeuvre needs enhancing. There is a shortage of some equipment and of both Regular and Reserve personnel. Nevertheless, current operations are being sustained, albeit with harmony being broken in some "pinch point" trades. Although I continue to have some reservations over the continuing willingness and/or ability of the Reserves to support mature operations, there is no sign of reduced commitment at present.

b. 'Moral Component'. I am less sanguine about collective clinical performance. The Bristol and the Shipman enquiries were landmarks in the modernisation of healthcare delivery in the UK. The main characteristic of both was the transfer of responsibility from individual doctors to the owning organisation. Bristol has led to significant developments in hospital services, whilst those changes that follow from Shipman are still in the process of being implemented. Developments in hospital care used to enter the operational medical services via those in the AMS Command and Staff Stream who were running Service Hospitals. The AMS no longer has responsibility for running peacetime hospitals, and there remains a danger that we will also be excluded from the management of peacetime primary healthcare. In retrospect it has become clear that on Op TELIC we did not initially have in place those system processes that are now considered an essential element of a modern healthcare service. Indeed, significant debate continues about how these should be implemented in Iraq today. Worse, the continued high tempo of deployments coupled with the dispersal of uniformed secondary healthcare staff has adversely affected our ability to conduct collective clinical training. In the Crimea, where the medical services of the time were roundly criticised, we were successful on the military side but failed in the 'moral' component. There is a danger that the same criticism could be levelled today, and it is this that I must prevent."

8. As a consequence a number of actions were taken. First, PJHQ accepted my advice that we needed to undertake a review of Clinical Governance in Iraq, and agreed to me sending a 3 man team with the specific remit of enquiring into the Quality Assurance processes, led by Brigadier Jonathon Freeman who was my TA Adviser and had been the Clinical Governance lead at University of Birmingham NHS Foundation trust (UHBFT) and included Colonel Rosie Kennedy, a TA Officer and the Chief Nursing Officer for Wales and Colonel Pete Sokolow who had been Commanding Officer of the Duke of Connaught Military Hospital in Belfast and had clear ideas on Clinical Governance in a hospital setting. Secondly, HQ LAND accepted my advice that all deployable Army Hospitals should come under command of 2nd Medical Brigade for a variety of reasons, including ensuring consistently high standards and appropriate preparation for deployment.

9. I also visited Iraq in December 2004, for the second time, and my own observation and that of the team led by Brigadier Freeman confirmed the requirement to formalise the Clinical Governance processes. This, and a number of other issues that I raised, also led to then Deputy Chief of Staff (Health) concluding that there was a need for a formal review of the DMS's operational capability and he obtained agreement for the appointment of a DG Med Op Cap, for which I was subsequently selected.

10. I became DG Med Op Cap in July 2005. As well as looking into the wider DMS Operational Capability, I was also asked to undertake a review of the overall manpower requirements (peace and operations) of the DMS. The outcomes were recommendation of the overall manpower requirements, which were announced in Parliament and in the DG Med Op Cap Report to which I draw the Inquiry's attention.

11. In October 2006 I became SG. Early in my tenure I took 2 actions which had significant impact. I entered into discussions with the Chair of the Healthcare Commission (HCC) with a view to the HCC undertaking a review of our Clinical Governance processes, which were already rapidly evolving as a result of my work as DGAMS and DG Med Op Cap. This required the amendment of legislation and thus the endorsement of Ministers of the Department of Health and of MOD, which was given. I also agreed with VCDS that the stalled review of the top structures of the DMS should be restarted under the leadership of my successor as DG Med Op Cap (Surgeon Rear Admiral Raffaelli who subsequently succeeded me as Surgeon-General) under the title "*Top Structures, Next Step*" ('TSNS'). The HCC Review also included a visit to Iraq and it reported in March 2009 [2]. The HCC Commission identified Trauma Management in military operations overseas in war zones to be an area of exemplary practice. This has subsequently been reported by the NAO whose report was issued in February 2010[3].

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[2] Healthcare Commission: Defence Medical Services – A review of the clinical governance of the Defence Medical Services in the UK and overseas (March 2009)

[3] National Audit Office: Ministry of Defence – Treating Injury and Illness arising on Military Operations (10 February 2010)

12. The TSNS Study has resulted in a number of major changes relevant to the conduct of current and future operations. Previously, SG was responsible for the policy and standards for healthcare but had little authority to implement them or indeed to confirm that they had been implemented. SG also shared responsibility with a Deputy Chief of Defence Staff (Health). From an operational perspective, TSNS has led to 4 major changes. It has resulted in SG been recognised as one of the 5 Process Owners within MOD, providing him additional authority across Defence for which he is responsible to the Defence Board. It has disestablished the post of the Deputy Chief of Defence Staff (Health), thus clarifying where responsibility for healthcare lies. It has established a one star Inspector General who is the eyes and ears of the SG, enabling SG to ascertain whether his policies and standards are indeed being implemented. And it has established a one star clinician as a Medical Director who will lead on developing the clinical practices of the DMS so that the DMS continues to be able to provide the highest quality of clinical care on operations.

13. Turning to the specific issues raised by the Inquiry and not covered above.

My role

14. In terms of priorities, the operational matters have consumed the majority of my time and indeed that of my staffs. This has resulted in a number of other areas receiving less attention than would otherwise be the case, and for example I and my staff recognise there is more to be achieved in the area of peacetime primary care. My declared main effort as SG all covered operational issues (Pain, limb salvage, infection control and prosthesis).

The Defence Medical Services

15. The DMS continues to comprise 3 separate Single Service medical services. However as explained above SG as a 'Process Owner' now has greater authority to ensure coherence between them whilst increasingly the provision of personnel in deployable hospitals is tri-Service. To date, the DMS has been able to handle in-Theatre all operational demands made upon it. Whilst managing the rehabilitation workload has been my major risk area, to date it

has been managed and resources have been made available to expand these in response to the workload.

16. The DMS has always relied heavily upon Reserves, and should continue to do so particularly in deployable hospitals where they have the greatest utility. The limitation of Reserves does however need recognising. They have had little utility forward of the hospitals; they usually deploy for half the time of Regulars; Reservists do not have the time to undertake some of the advanced training provided to Regulars; and few have the tactical skills that enables safe deployment forward. There are also potential threats from the future nature of civilian medicine, from increasing sub-specialisation, shorter training timing and increased pressure from civilian hospitals to deliver the hospitals' business. The NHS drive for greater efficiency might also have a detrimental effect upon availability of NHS staff as reservists.

17. The DMS has tried Sponsored Reserves, but for a variety of reasons they have not provided a significant contribution numerically though they have been important in a number of critical areas.

Provision of Treatment for Injured Personnel

18. The HCC and NAO reports address the quality of deployed care for injured personnel. Data also indicates increased survival which is the result of a number of clinical initiatives, supported by equipment enhancements (eg CT Scanners). The clinical care provided at UHBFT (Selly Oak) has also always been high quality although in the early parts of the campaign there were significant deficiencies in the welfare support to casualties and their families which took some time to correct. Regrettably, as the House of Commons Defence Committee Report noted, the press exploited these issues and I quote from that report[4]:

> *"It seems clear that there has been much inaccurate and irresponsible reporting surrounding care for injured Service personnel at Birmingham, and that some stories were printed without being verified or, in some cases, after the Trust had said that they were untrue. We*

[4] House of Commons Defence Committee: Medical Care for the Armed Forces (Seventh Report of Session 2007-08). Printed 5 February 2008

condemn this completely. Editors have a responsibility to ensure that their newspapers report on the basis of verified fact, not assumption or hearsay. The effect of such misrepresentation on the morale of clinical staff and Service personnel and families was considerable. We consider the publication of such misleading stories as reprehensible."

19. The increasing complexity of injuries accompanied by increased survival is however posing difficulties which are still being addressed. These complex survivors started to be seen in 2006/7 and the individuals affected are only just coming to the point where the difficulties require addressing, and the DMS and the NHS are currently in a learning period as we explore how to deal with these individuals. I cover this in more detail below.

20. Mental Wellbeing is, and always has been, a major pre-occupation of the Armed Forces and its medical services. The greatest barrier to individuals receiving high quality mental health services is stigma, and although this is improving it has not been eliminated in either our Armed Services or indeed that of any other nation. It is also an issue in civilian life. Most effort goes in prevention. The arduous nature of training, the development of team spirit, the introduction of Trauma Risk Management (TRiM - undertaken within a group by a group member and not by inserted health professionals), providing a short period of decompression before returning home are the most prominent examples of prevention. The presence of Community Health Nurses in deployed Theatres, supported by visiting psychiatrists, education of primary care physicians, Community Mental Health Teams and contracted NHS in-patient care provide a medical back-up. PTSD is rare (though can be serious for those affected) with other mental health conditions such as depression and alcohol mis-use being more common. I believe that we are doing better than in previous conflicts and that we are doing at least as well as our Allies whilst recognizing that neither we nor any other Armed Force has yet fully resolved the issue.

21. I shall not address the provision of support for Reserve Forces after their demobilisation, nor their families nor veterans and their families in my statement as I did not have any responsibility for these, other than as an advocate.

Co-ordination

22. The provision of medical care on operations has been a national effort, involving both Governmental and non-Governmental institutions, and has also drawn on international partners. Indeed, the main 'value added' of a SG is his ability to harness and co-ordinate such effort.

23. The contribution of the hospital sector of the NHS is well known. Less well known is the contribution of a variety of other NHS bodies. The life-saving innovation of the massive transfusion protocols would never have been possible without the whole-hearted support of the National Blood Transfusion Services who have provided the DMS with whatever it has requested. The Health Protection Agency has provided advice and assistance on a variety of issues. We have had on occasions to use drugs un-licensed in the UK or for a purpose for which they are not licensed and the Medical and Healthcare products Regulatory Agency (MHRA) has provided advice and assistance to enable us to comply as closely as possible with Regulation. A number of the Royal Colleges have provided clinical advice and support, and have agreed to the appointment of a number of Joint Professors as a mechanism for further developing clinical excellence. A variety of charities, such as the hearing charities, have sought to provide us with advice and in some cases practical support, for example Deafness UK co-sponsoring a major conference on Noise Induced Hearing Loss. The Chief Medical Officers of England and the Devolved Administrations have offered me personally advice and support, and the national Director for Trauma for England has engaged with us, and indeed visited Afghanistan with me. The Medical Research Council continues to consider its role in future trauma related research and I arranged for the CE to visit and be briefed by the US on their research effort.

24. One issue which is relevant to the questions put is that of the future management of our serious complex cases. These are relatively few in number and it will be difficult for local civilian services to develop expertise in managing them, and indeed may become even more difficult as a result of potential changes in the NHS. They will also have evolving needs as they age. The responsibility does not lie with MOD, but MOD clearly has an

interest in ensuring that these casualties are managed appropriately. Adopting the approach of the US Veterans Agency, briefed to me by their Secretary, termed 'Life Care Planning' was identified as a potential approach and there was no difficulty in arranging a high level meeting at 2–3 star level with major representation from different parts of the DH (including their Department of Health's Director General of Social Care and their Director General of Policy and Strategy), the Devolved Administrations and DWP. Our Minister subsequently engaged at his level.

25. Equally important has been the contribution of Allies, and in particular the US who started to experience significant numbers of casualties before us. The US has made research undertaken by them freely available to us and initially it was the outcome of their research that after due diligence enabled us to make the advances that we have introduced. Increasingly we have also been providing research outputs that we have shared with them. The attendance in the US of our clinicians at their clinical conferences, the placing of one of our clinicians at their primary research establishment has been instrumental in this, with our clinicians increasingly providing input and myself being asked to be a key-note speaker at a number of their major conferences. This cooperation also exists in the operational Theatre and I am aware of one occasion when we deployed a ward's worth of nurses to assist the US during a particular battle whilst we have made use of other nations clinical teams within our medical establishments. The US has also hosted at least one conference in the UK to tap into our expertise and has undertaken visits to see our approaches to various issues.

26. These informal relations are supported in the UK by the MOD-NHS Partnership Board and internationally through the NATO Committee of Surgeon Generals (COMEDS).

27. Advice to Ministers and (usually via VCDS) the Chiefs of Staff is part of routine business and was both reactive (responding to concerns raised by them), proactive (bringing to their attentions my issues) and routine.

28. I would prefer to address the impact of the media during oral evidence.

Lessons Learned

29. The DG Med Op Cap Report articulates the majority of the general medical Lessons Learned from the Iraq campaign. In addition, we have developed improved processes and more advanced clinical care as operations progress. We also need to recognise and take account of the fact that much of the clinical success has been due to the emergence of a number of young, enthusiastic and able Regular hospital consultants mentored by a small number of 'survivors' who remained after the major personnel outflow following the Defence Cost Study of 1996.

30. However, I recognise that there are still issues to address and some of these (such as Life Care Planning and also continuing to explore means of reducing the psychological impact of operations) I refer to above. There are of course others, such as addressing the rate of illness on deployed operations and determining the balance between in-Theatre treatment and evacuation to the UK.

Statement of Truth

31. I believe that the facts stated in this witness statement are true.

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Dated this 15 day of July 2010

Louis Patrick Lillywhite