

# Saying sorry

Saying sorry meaningfully when things go wrong is vital for everyone involved in an incident, including the patient, their family, carers, and the staff that care for them.



**Saying sorry is:**  
**always the right thing to do**  
**not an admission of liability**  
**acknowledges that something could have gone better**  
**the first step to learning from what happened and**  
**preventing it recurring**

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### **Why?**

Not only is it a moral and right thing to do - it is also a statutory, regulatory, and professional requirement. It can also support learning and improve patient safety.

### **When?**

As soon as possible after you become aware something has gone wrong you should seek out the patient and or their family and say sorry and acknowledge what has happened and tell them that you will find out more. Reassure them that you will keep them informed.

### **Who?**

Everyone can say sorry, but you may need to be supported to do so. You may need the backing of more senior people and staff may need training but it should not stop you from simply saying

sorry. As part of an initial apology it is best practice to provide the patient and their family with a key contact wherever possible.

### **What if there is a formal complaint or claim?**

The Compensation Act 2006 states; 'An apology, an offer of treatment or other redress, shall not of itself amount to an admission of negligence or breach of statutory duty'. (source: [Compensation Act 2006 – Chapter 29 page 3](#))

In fact, delayed or poor communication makes it more likely that the patient will seek information in a different way such as complaining or taking legal action. The existence of a formal complaint or claim should never prevent or delay you saying sorry.

### **How?**

The way you say sorry is just as important as saying it. An apology should demonstrate sincere regret that something has gone wrong and this includes recognised complications referred to in the consent process. It should be confidential and tailored to the individual patient's needs.

Where possible you should say sorry in person and involve the right members of the healthcare team. It should be heartfelt, sincere, explain what you know so far and what you will do to find out more.

It is the starting point of a longer conversation; as over time this will lead to sharing information about what went wrong, what you will do differently in the future. It is vital to avoid acronyms and jargon in all communications.

You may also need to say sorry in writing where significant harm has been caused or in response to a written complaint. An example of this could be:

“I wish to assure you that I am deeply sorry for the poor care you have been given and that we are all truly committed to learning from what happened. I apologise unreservedly for the distress this has caused you and your family”

### What about the Duty of Candour?

The statutory Duty of Candour requires all NHS staff to act in an open and transparent way. Regulations governing the duty set out the specific steps healthcare professionals must follow if there has been an unintended or unexpected event which has caused moderate or severe harm to the patient.

These steps include informing people about the incident, providing reasonable support, truthful information and an apology. Saying sorry forms an integral part of this process. Process should never stand in the way of providing a full explanation when something goes wrong.

#### Don't say

- x I'm sorry you feel like that
- x We're sorry if you're offended
- x I'm sorry you took it that way
- x We're sorry, but...

#### Do say

- ✓ I'm sorry X happened
- ✓ We're truly sorry for the distress caused
- ✓ I'm sorry, we have learned that...

*“We have never, and will never, refuse cover on a claim because an apology has been given.”*

Helen Vernon, Chief Executive, NHS Resolution

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### For more information

Nursing and Midwifery Council & General Medical Council joint guidance on openness and honesty when things go wrong

[www.gmc-uk.org/guidance/ethical\\_guidance/27233.asp](http://www.gmc-uk.org/guidance/ethical_guidance/27233.asp)

Reports and consultations on complaint handling (Parliamentary and Health Service Ombudsman)

[www.ombudsman.org.uk](http://www.ombudsman.org.uk)

AvMA (Action against Medical Accidents) Duty of Candour leaflet [www.avma.org.uk/policy-campaigns/duty-of-candour/duty-of-candour-leaflet](http://www.avma.org.uk/policy-campaigns/duty-of-candour/duty-of-candour-leaflet)

Care Quality Commission - Regulation 20: Duty of Candour [www.cqc.org.uk/content/regulation-20-duty-candour](http://www.cqc.org.uk/content/regulation-20-duty-candour)

If you want to get in touch [safetyandlearningenquiries@resolution.nhs.uk](mailto:safetyandlearningenquiries@resolution.nhs.uk)

The Patients Association  
<https://www.patients-association.org.uk>

### The NHS Constitution

Patients: “you have the right to an open and transparent relationship with the organisation providing your care. You must be told about any safety incident relating to your care which in the opinion of a healthcare professional, has caused or could still cause significant harm or death. You must be given the facts, an apology, and any reasonable support you need”.

Staff: “you should aim to be open with patients... if anything goes wrong; welcoming and listening to feedback and addressing concerns promptly and in the spirit of cooperation.”