

## Health Service Safety Investigations Bill

Second Reading, House of Lords, Tuesday 29 October 2019

### Summary

- The Parliamentary and Health Service Ombudsman was set up by Parliament to provide an independent service to handle complaints about the NHS in England, UK Government Departments and other UK public organisations. We are the final stage for complaints that have not been resolved through the organisation's own complaints process.
- Provisions within the Bill will enable the new Health Service Safety Investigations Body to carry out its own investigations in 'safe space'. This will help to drive improvements in the NHS through promoting a culture of speaking up and learning from mistakes.
- However, it is vital for us to have access to information held in safe space to carry out investigations into the complaints we receive. Without this, we may in some cases be unable to put things right for those who have suffered injustice or hardship as a result of failures in public services and confidence in the system may be undermined. **During the passage of the Bill, we therefore would welcome amendments to remove the prohibition on HSSIB disclosing information held within the safe space to PHSO.**

### Background

The Health Service Safety Investigations Bill ('the Bill') sets out legislation to establish an independent body to investigate patient safety incidents and promote a culture of learning within the NHS. The new body will have the powers and independence to conduct investigations into incidents that occur during the provision of NHS services or that could have an impact on the safety of patients. It is expected that the new body will carry out around 30 investigations a year.

### Safe space provisions in the Bill

The Bill makes provisions for creating a 'safe space' within HSSIB investigations. This will enable clinicians and others to take part in, and provide information to, these

investigations without the fear that this will be disclosed or used for disciplinary purposes. This builds on the ethos of the new body's predecessor, the Healthcare Safety Investigation Branch, which already abides by the safe space principle in carrying out their current investigations.

In our submission to the Joint Pre-legislative Scrutiny Committee, we welcomed the prohibition on disclosure of information held by HSSIB in a safe space as this will help to create a culture where people working in the NHS feel it is safe to speak up when things go wrong.<sup>1</sup> We have seen many examples in our casework where poor investigations or a fear of blame have hampered efforts to understand what went wrong in a patient safety incident and what can be done to prevent similar failures happening in future.<sup>2</sup>

### **Why PHSO needs access to information held by HSSIB in safe space**

Provisions set out in the Bill, if implemented, will have a widespread impact on people who use NHS services. In the likely small number of cases where we receive a complaint about a matter investigated by HSSIB, if we do not have access to information held by HSSIB within safe space, there is a risk that we will not be able to carry out the full and effective investigations. This will have significant consequences for citizens by limiting access to justice for those who have suffered harm as a result of safety failings in the NHS, as well as prohibiting us from using our investigations to drive learning and improvement in the safety of care. As a result, this could undermine public trust in the integrity of the NHS and its ability to learn from when things go wrong.

If the legislation is passed in its current form, it will severely limit our statutory powers to access evidence or compel witnesses for the purpose of our own investigations. (The powers granted to us by parliament are the equivalent to those of the High Court.<sup>3</sup>) We could therefore be significantly impeded from accessing information that could be pivotal in investigations or complaints about HSSIB or care provided in a situation HSSIB has investigated.

There is a danger that a patient or their family member, when pursuing a complaint about treatment, could find that a contradictory account had been given by a witness - one to HSSIB in safe space that is not seen by the ombudsman, and another to the ombudsman about what happened and why. This could lead to the ombudsman making incorrect or incomplete recommendations for either individual or systemic remedy, as well as the potential for litigation by the complainant to resolve the conflicting accounts.

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<sup>1</sup> <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/draft-health-service-safety-investigations-bill-committee/draft-health-service-safety-investigations-bill/written/84432.html>

<sup>2</sup> <https://www.ombudsman.org.uk/publications>

<sup>3</sup> Under Section 12 of the Health Commissioner Act 1993 and Section 8 of the Parliamentary Commissioner Act, my Office has the power to require individuals and organisations to produce information and provide documents relevant to an investigation.

A further issue is that as HSSIB will come under the parliamentary jurisdiction of the ombudsman, it could be very difficult to investigate a complaint about their handling of an investigation, without accessing the information which the complaint is about. Applying to court to obtain this information could bring the integrity of the patient safety system into disrepute.

In addition to the impact that this will have on families who complain to us and for citizens using the NHS, if we do not have access to all information when considering serious cases, including that which is held within safe space, this could reduce confidence in the findings of any of the type of investigations highlighted. It is worth noting that if we receive such a complaint, it will be because either a patient, family member or carer believes that something has gone wrong. If we cannot provide assurance that we have been able to investigate all of the relevant evidence in their case it could deny them both closure and, if the evidence we are denied suggests there has been maladministration, access to justice.

### **Coroners' access to safe space**

During Pre-Legislative Scrutiny of the draft Bill, the Government indicated that the number of organisations who would have access to safe space would be limited in order to protect the integrity of the domain. Since then, the Bill has been revised and now exempts coroners from these restrictions, enabling them to request access to information held within safe space for the purpose of their coronial inquests.<sup>4</sup> **Given the parallels with our own situation, we are requesting that the Bill be amended to remove the prohibition on HSSIB disclosing information held within safe space with PHSO.**

We believe it is contrary to the public interest to allow HSSIB to share safe space information with coroners and not with PHSO. As we have a statutory obligation to investigate in private, we can therefore provide strong assurances that any protected information disclosed to us by HSSIB would not enter the public domain as it is protected from disclosure under the Freedom of Information Act. Moreover, we do not and cannot share information obtained as part of an investigation with coroners due to our strong provisions to investigate in private.

Parliament has provided for its Ombudsman to be able to access a wide range of highly sensitive information from all Government Departments and the NHS, with a statutory requirement to also investigate in private. Given this, creating a specific statutory bar for HSSIB that requires us to go to the High Court (when in all other circumstances we have the power of the High Court) seems disproportionate and a potential waste of taxpayer's money on unnecessary litigation. We are committed to working closely to HSSIB to ensure that any information we are provided in the course of an investigation

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<sup>4</sup> Clause 19 will allow HSSIB to disclose information held in safe space to a senior coroner who has, or could, require the information to be disclosed under schedule 5 of the Coroners and Justice Act 2009.

is handled and used appropriately as is the case for the thousands of sensitive cases and information we already consider each year.

**Contact:**

Heather Ransom, Public Affairs and Insight Manager  
Parliamentary and Health Services Ombudsman

E: [heather.ransom@ombusman.org.uk](mailto:heather.ransom@ombusman.org.uk)

T: 0300 061 4242