



HOUSES OF PARLIAMENT

Joint Committee on the Draft Health Service Safety Investigations Bill

Oral evidence: Draft Health Service Safety Investigations Bill, HC 1064

Monday 18 June 2018

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Written evidence from witnesses:

- [Action Against Medical Accidents \(AvMA\) \(SIB0021\)](#)
- [Scott Morrish \(SIB0035\)](#)

Members present: Sir Bernard Jenkin (Chair); Baroness Billingham; Baroness Chisholm of Owlpen; Baroness Eaton; Lord Elder; Mr David Jones; Lord Kirkwood of Kirkhope; Andrew Selous; Baroness Watkins of Tavistock; Paul Williams.

Questions 165-223

Witnesses: **Imelda Redmond**, National Director, Healthwatch England, **Peter Walsh**, Chief Executive, Action Against Medical Accidents, and **Scott Morrish**, Patient advocate and father of Sam Morrish, gave evidence.

Q165 **Chair:** Welcome to this session on the draft HSSIB Bill. Would you each identify yourself for the record, please?

Imelda Redmond: I am Imelda Redmond, national director for Healthwatch England.

Peter Walsh: I am Peter Walsh, chief executive of the patient safety charity Action against Medical Accidents.

Scott Morrish: My name is Scott Morrish. I am the father of Sam Morrish, and as a result of his avoidable death I ended up spending some years in the complaints system.

Chair: Thank you all for joining us. I have a very general first question, to give each of you the opportunity to explain a bit more about your perspective. What have you observed in the NHS when something goes wrong?

Scott Morrish: Unreliable responses; a system that feels like it is under pressure. It can be very defensive; it can be very closed. It is not necessarily that people do not want to do the right thing, but they often feel unable or afraid to do the right thing, and sometimes they are

stopped from doing it. As a result, you end up with people spending years and years in adversarial contact, which exaggerates that whole context and keeps it rolling on.

Peter Walsh: All of the same, plus great inconsistency across the NHS. Some NHS bodies have become quite good and professional at carrying out investigations; others are still on the starting blocks and are ill prepared and ill resourced to carry out professional in-depth investigations. Things are beginning to change, but it has not been uncommon in the past for there to be over-defensiveness, which sometimes has stretched into downright dishonesty when things have gone wrong. Things have begun to change in that regard because of the duty of candour the Government brought in in 2014. We believe that that is beginning to show signs of changing the culture and the approach, but one of our concerns about the draft Bill, as we will be discussing, is that the provisions for the safe space are entirely inconsistent with the principles of a duty of candour.

Chair: We will come to that. We note your concern and are very interested to explore it.

Imelda Redmond: There is a Healthwatch in every part of the country, so we get feedback from right across England, and what people tell us is that there is an inconsistent response. In some places it is very good—people feel held in the process and that the process is explained to them and is taken forward appropriately—but in many places they feel left on their own, isolated, and do not know where they are in the process. They are just the individual or the family trying to find their way through a complicated system that might go across a number of NHS or social care organisations, and they have no idea where they are in any of the processes. All they want is honesty, resolution and for it not to happen again, but they often feel left in a quagmire, where there is not enough empathy for what the families are talking about, regardless of process.

Q166 **Baroness Chisholm of Owlpen:** Following that, we keep hearing conflicting accounts of the culture in the NHS, but that it is changing in relation to its openness and candour. Have you observed any improvements since this openness has supposedly come into place in this area?

Imelda Redmond: My answer is quite straightforward. People often come to Healthwatch when they are unhappy; they rarely get in touch with us to say, “There’s been a great complaints procedure and I’ve got resolution.” We are still getting the same types and numbers of people expressing their frustration about how they get redress when things go wrong.

Q167 **Baroness Chisholm of Owlpen:** So the numbers have not dropped?

Imelda Redmond: The numbers have not dropped, but they have not dropped across anything. In some areas they have gone up—right across everything that Healthwatch looks at—partly because we have been around a bit longer, I think.

Peter Walsh: Similarly, we deal with about 3,000 people a year who have been affected by lapses in patient safety, and while we do not have conclusive evidence yet about how things have improved, anecdotally we are getting feedback from patients, and also crucially from staff, saying that, particularly since the introduction of the duty of candour, it has empowered them to give the message that it is not optional anymore; that it is not just guidance that they

should be open with patients and families when things go wrong, but they have to be open by regulation, by law, and they are running the risk of being criticised or worse by the Care Quality Commission if they are not.

It takes time for that cultural change to bed in, but I think we are beginning to see the difference that people are increasingly going to full openness as the natural approach. But we still hear stories from staff about them feeling fearful. We are all for measures that can be taken to give genuine protection and safe space to staff who are trying to do the right thing, who might be quite unintentionally the last person in a chain of events—basically a system error—that led to harm, and who all too often are hung out to dry or unfairly treated by their employers. The best way to do that is not to hide information or make it secret, but to empower the freedom to speak up guardian, to make that a real safe space for people, so that employers are not able to take unfair action against their staff. Also, there is a need to reform the law pertaining to whistleblowers, so that they are genuinely protected. Those two things would make a genuine difference, for a start.

Q168 Baroness Chisholm of Owlpen: Can you say a bit more about the speak up guardian and how that is working?

Peter Walsh: In the wake of the Mid Staffordshire inquiry, Sir Robert Francis did some work on the plight of whistleblowers and how they could be protected. One of the measures was the introduction of local freedom to speak up guardians in NHS trusts—people to whom trust staff could speak with a degree of confidence. A national office was also established. The national freedom to speak up guardian promotes openness and fairness for staff to speak up. It is early days in their tenure, but I think the main criticism has been that they have not enough capacity or powers to be a genuine safe space for people.

Scott Morrish: I can say only that I am convinced that there is greater awareness of all these issues. I cannot say whether it has improved sufficiently in practice. One thing to note is that we may now have a duty of candour, but I do not think that equates to people feeling safe, which would be my argument for the safe space.

I applaud both initiatives. We should have a duty of candour; it should be what we expect from healthcare professionals, but we should also provide those healthcare professionals with a safe space and we should do the same for patients. So I would give a slightly more nuanced response.

Q169 Baroness Watkins of Tavistock: Where you say things are improving, is that predominantly in acute trusts, or do you think they are also improving in mental health and learning disability services?

Peter Walsh: I would sound a note of caution about my observations, because they are largely anecdotal. I know there is research being conducted by, among others, the University of Leicester, which will give us more hard evidence on that. However, our sense is that it is improving across the board. Perhaps where we have less intelligence and less reason to be confident that things have really moved significantly is in primary care. Primary care has come later to the party and it is, quite frankly, harder to instil that cross-system change through all primary care than it is among NHS trusts.

Q170 Baroness Eaton: You talked about openness quite a lot in that response. How will the safe space investigations undertaken by HSSIB contribute to a more open culture?

Scott Morrish: It is hard to talk about safe space, given the way that the draft Bill has been written, without separating out two very different intentions that the Bill seems to have. I am completely convinced that a safe space locally is the wrong approach, but equally convinced that a safe space within the healthcare safety investigations branch is essential. I think it is necessary to equip the NHS with something it should always have had, which will be its first opportunity to look across the whole system, speak to anybody without any boundaries getting in the way and find out precisely what happened from as many different perspectives as possible, in order to generate learning that constitutes a basis for improvement. My fear with the implementation of that locally is that it simply will undermine trust and credibility for HSSIB. In any answer, I have to separate those two things. I don't know if that helps.

Peter Walsh: I too distinguish between the two. I happen to have a slightly different opinion from Scott's, even as regards HSSIB itself, about whether the safe space as described in the Bill actually does anything helpful or positive at all. I think it is a bit of a misnomer because it is actually a prohibition on being fully open and on disclosing information that is found out in an investigation. If one analyses the wording of the Bill closely, it is a prohibition on the sharing of any information. There are some exceptions—in fact, there are numerous exceptions—but the one notable area where there is not an exception is the patient or the family who have been affected. They are the ones who are not trusted with the information, even though it is about what happened to them.

That is in stark contrast to the recommendation of the expert advisory group that was established to recommend how HSSIB should work. It concluded on this very difficult issue, on which there are different shades of opinion, that any relevant information about the treatment of the patient must be shared with the patient or their family, and they should be free to do with it what they wish. Yes, we should protect some of the information in other ways from certain usages and go away and find more meaningful and robust ways of protecting staff from unfair treatment, but being unfair to patients and families with what they can see was not considered a viable option.

Imelda Redmond: From a Healthwatch perspective, I would agree with my colleagues on a distinction between national and local levels. There are considerable concerns about investigations happening at a very local level and you can imagine how that would feel if you were already feeling very vulnerable because you or a family member had been through a very difficult time, and then that was dealt with by the people who you would think are responsible for it. What you do not want when you set up any of these systems is to breed cynicism in the systems and processes, and you could see cynicism coming in quite quickly there.

When it comes to a national position, there is absolutely a role for professionals and people affected to have an honest, candid learning opportunity to really change things—I think the general public would assume that that is what happens when things go wrong anyway—but I would agree with Peter about the importance of bringing the families or the patients in as partners, because their knowledge and learning is an important part of the whole picture. It is

about them at the end of the day. It is about learning in the NHS, but you can learn only if you really engage people properly in that process.

We do not have a strong opinion that there should not be a safe space at a national level. We have a strong opinion that it is a good idea, but how it is done really matters. You would need to look at it quite differently at a local level, because of the power imbalance between the families and the staff and the institution.

Chair: We will come back to all of that, unless anybody has a supplementary.

Q171 Baroness Chisholm of Owlpen: I think Scott wanted to say something.

Scott Morrish: I was going to say that the characterisation of safe space is important. I strongly disagree with the way it has just been described by Peter, for example. It is not a prohibition on honesty or openness; it is simply, in the context of a national safety investigation's capability, a space where everybody can be fully confident in being open and honest, so the investigators can draw whatever learning is necessary.

The expectation, and my hope for HSSIB doing a good job, would be that it would then include everything that is relevant in its final report, and thereby it will come back to the family. The family is benefiting from this as much as everybody else. The risk in thinking of it as a prohibition is that it sets the hares running and raises all kinds of fears that are not necessary. We have a system without the safe space, and we have what we have. This is our moment to try something different and I think the safe space is an important part of that.

Q172 Chair: Do you want to respond to that, Mr Walsh?

Peter Walsh: Yes. Obviously the main concern, as you have heard from all of us, is the local investigations, because here you have the potential of trusts investigating each other or even themselves. There is a quite obvious conflict of interests.

Chair: We will come to that later.

Peter Walsh: Okay. Just to respond to what Scott said, we have to look at what the draft Bill actually says. It describes a legal prohibition on the sharing of information from investigations, and the breadth of that information is not narrowed in any way by the draft Bill. It is literally any information.

In the early days, when safe space was being discussed in the context of HSSIB, I remember civil servants trying to placate my fears and worries about it by saying, "Oh, don't worry, Peter; this will only be primary evidence. It's the personal evidence that staff give in the form of witness statements, interviews, et cetera." One might argue that there is a credible argument for treating that differently. However, the Bill does not treat that any differently; it is any information.

Civil servants told me, "Families needn't worry because at the end of the process, just trust us and an investigation report will tell you all the findings of fact that you need to know." Again, you could argue that if that was always happening that is a good thing. However, you

will note from the Bill that there is a ban on the use of any of the findings of fact in the final report itself in, for example, a civil procedure.

Think about that for a moment. If we do what it is saying in the Bill you are prevented, at both ends, from being a part of the investigation, and a full partner in the investigation. How can you be a full partner if you are not entitled to see the information that is being found by the investigation? Even when the investigation draws its conclusions, findings of fact and recommendations, you are not allowed to do anything with it. You can see what has happened, but if you had, for example, a clinical negligence claim, you would not be able to use that information.

One of the fears we have is that at the moment when people say to us, “Something has gone terribly wrong. There’s going to be an NHS investigation. Should I speak to lawyers now, or should I let them do the investigation?” we are able to assure them, and say, “Look—give the NHS a chance, because the people by and large will try to conduct a good investigation. They are bound by the duty of candour. They will share everything with you. Come back to us for advice later on.” For most people, if a good investigation is carried out and they are dealt with honestly, that is all they want, as Imelda said.

This prohibition on disclosure would have what I think is the opposite of the intended effects. It would destroy confidence and create an adversarial culture. People will be saying, “We know for certain, because of the legislation, that trusts, even if they wanted to—if they are one of these accredited trusts—would not be allowed to share information, and even if they give us the report at the end, we cannot use it for anything.” So they will say to us, “Find us the best lawyer you’ve got.” They will get angry. They will seek disciplinary action. So, it is actually counterintuitive to the just culture—the open and fair culture—that all of us would like to see.

Q173 Lord Kirkwood of Kirkhope: Thank you, first of all, for the various written submissions you have made. You have just been demonstrating some of the nuances of the different positions that you take, but your collective experience is extremely valuable to the Committee in its deliberations. I can take you to slightly easier territory, because I would like to spend a moment or two on trying to solicit your views on the scope of the Bill. We have heard some concerns that it is maybe too focused on acute secondary-type situations and we would want to deal with that, if that is the case. Do you believe there are real risks outside the acute sector, in the community service, dentistry, pharmacy or some other thing? Is that something that this Bill needs to be more attendant to? If that is the case—you have a wealth of experience between you—do you have any community-based incidents? You have been able to help us to understand some cases very clearly, which help inform the Committee. If there are any cases that are outside the acute sector, we would be pleased to have those as well. Maybe you can do that best in a note. The big question is, will you talk to us about what you think the scope of the Bill really should be, to cover the questions adequately?

Scott Morrish: It should be unboundaried. Wherever a health safety investigation needs to go, it should go unboundaried. Otherwise, it is not a whole system. In my son’s case, he died in a hospital. But first, we went through our GP, then our out-of-hours GP, then NHS Direct—which would now be 111—and then he died. The adverse incident may occur in an

acute setting, but its roots almost certainly lie somewhere else, and the safety investigation has to be able to follow wherever that may lead. It may lead back to a dentist or a pharmacy, or any number of other settings. It should be free to go where it needs to go and we should empower it to do that, and then monitor that it does it sensibly.

Q174 Lord Kirkwood of Kirkhope: Unbounded means quite a lot of money to do this job properly and we are dealing with an impact assessment where the Government are suggesting that there would be 30 proper, full, independent investigations per year. Are you saying that that would not be adequate to providing an unbounded public service?

Scott Morrish: I am not commenting on that specifically. I am saying that if you want a safety investigation branch to find out where the roots of adverse incidents lie, you have to make sure that it is not siloed in some way. At the moment, all of our regulators, our complaints system, everything we have, are all broken down into little silos. They all look within their little silos and they look no further. They are not really interested in what lies beyond their silos. Don't create another one!

Lord Kirkwood of Kirkhope: That seems quite clear to me.

Peter Walsh: I would agree with Scott. There should not be any boundaries put in as to what HSSIB can choose to look at. It needs to investigate where it feels the maximum potential for learning and harm prevention is, be that primary care, community settings or acute. It absolutely should include primary care and community services.

Imelda Redmond: I would absolutely agree as well. One of the public's great frustrations with trying to take any complaint or improvement through is that they get stuck in these silos. As Scott said, the initial problem might have started in the GP's and lead to a terrible incident in a hospital. I have to say—I know this is outside of this Bill, so I will not ask you to put it in—that the public say to us that it might be happening in a care home, which is considered social care, and why would that be ignored? Social care and how you deal with complaints is a whole other piece of legislation. But from the public's perspective, they would not understand why you would not follow the journey, because that is what they are interested in, not the institutions.

Lord Kirkwood of Kirkhope: That is very clear. Thank you very much.

Q175 Mr Jones: I would like to return to safe space. We have heard from some witnesses that they believe the creation of safe space and its operation will militate against openness. I can see some of you nodding and some shaking your heads. I am interested to know what each of you thinks about that particular suggestion.

Peter Walsh: Safe space, as it is described in the draft Bill—not as some people would like to see safe space, which might look quite different—clearly militates against full openness and that open and fair culture that we aspire to. It does more than that, I think.

As I said earlier, it creates an environment where people are more likely to be adversarial and moving away from the more compassionate and co-operative culture that we aspire to in

terms of patient-safety incidents. It is entirely inconsistent with the principles of the duty of candour and potentially with the letter of the duty of candour.

Let me explain why I think that would be the case. Let's say, particularly if the local investigation by an accredited trust looking at itself has come in, a trust can only tell the patient or family what it knows at the time. At the nearest time to the incident, they may have fulfilled the duty of candour at that point, because that is all they know.

There is then an investigation. If the investigation is worth its salt, it is going to find out more information; otherwise, what's the point? Because there is a safe space, there is a prohibition on sharing that information with the patient or family concerned. They can have no information about it at that stage. They would, at the end of the process, then have sight of an investigation report, which would give the investigators' findings. Then there would be an opportunity, if you like, for the duty of candour to be followed. But even then, you would not be able to do anything with the information, because there is a prohibition on using it, for example, in civil procedures. You will find that in 33(2)(a).

Q176 Mr Jones: I would like to ask one or two further questions about that. As far as the professional providing evidence in safe space is concerned, to what extent is that professional constrained in complying with the duty of candour upon him or her when in the safe space process? In other words, does that duty not still prevail on that professional, notwithstanding that the safe space procedure has been implemented?

Peter Walsh: It creates an interesting conundrum. You are absolutely right: the professional duty of candour that doctors and nurses and others are bound by in their professional codes, still exists.

Q177 Mr Jones: That is not constrained by safe space?

Peter Walsh: It is not constrained by the safe space but it creates an inconsistency. If a health professional is complying with their own duty of candour, what is it that they are telling the investigation that has to be hidden from the patient or relative?

Q178 Mr Jones: Does it have to be hidden at all?

Peter Walsh: I would argue that it should not be hidden and there is no need. There is no practical benefit to staff. When I ask staff what they are frightened about when they take part in investigations, it is being badly treated by their employers, above anything else. I have spoken to more than 1,000 health professionals at conferences and training events that we run over the past 18 months, and I have put the question to them: "What are you worried about?" It is about employers.

When you ask them, "Would you want what you know, and therefore what you would give in evidence to an investigation, to be kept secret from the patient or family?", the answer is absolutely not. Would they want the patient or family to be constrained about using findings of fact to exercise a normal citizen's right to access justice? No, absolutely not. It delivers, as far as I can see, little or no good. It creates this confusion in people's minds. No one has really explained what kind of information it is that people are worried about patients or families seeing, given that it is about them.

Q179 **Mr Jones:** But in terms of openness, although a professional may be providing information in the safe space, that professional is also duty bound to comply with the duty of candour. Is that not right?

Peter Walsh: Yes, as I said, they are. Therefore, what does the safe space do?

Q180 **Mr Jones:** You are not suggesting that the safe space amounts to some sort of improper constraint on the duty of candour.

Peter Walsh: Ah! There are two duties of candour—I should explain. There is the professional duty of candour in every doctor and nurse's professional code. There is also the statutory duty of candour. The statutory duty of candour opens with a statutory obligation to be fully open and honest with patients and families. I would suggest that hiding information from them and prohibiting the disclosure of information to them goes against that general principle.

Q181 **Mr Jones:** Yes, I understand that, but that principle still prevails, surely. It is a statutory duty that that professional has to comply with.

Peter Walsh: The trouble is that at this stage, if you have a safe space investigation, the information goes into a black hole. If the trust has that information before the investigation, they are under a statutory obligation to share it with the patient and the family. If you create a safe space investigation, it becomes a black hole. You then have the prohibition on sharing any information, apart from what you publish at the end in a report, where then you tell the patient and family that you cannot do anything with it.

Q182 **Mr Jones:** Mr Morrish, you were shaking your head when Mr Walsh was nodding his.

Scott Morrish: We disagree about these things. Far from a black hole, I see the safe space as the possibility of shining a light. The information that can come to light in a safe space is currently not coming to light. That is just the way it is. It is not a question of deciding to put some information in a safe space that ordinarily is revealed; it is not revealed now because people are afraid. I agree that that is probably more a fear of the system, the regulators, poor governance, weak leadership or colleagues—whatever it happens to be. It is all those things and many more. That is the fear that stops some people saying stuff they know that could improve safety if it was shared.

What we are talking about the safe space creating is a place in which that can happen. All it means is that the witness statement is protected. No other information is protected. No one gains immunity or impunity through the space; it is simply a question of protecting the statement so that they can speak freely.

Q183 **Mr Jones:** I don't know whether you are able to answer this, but would you say that the safe space that is proposed to be created by the Bill is as safe as the safe space that prevails in the case of air accidents?

Scott Morrish: No.

Q184 **Mr Jones:** Do you think it should be?

Scott Morrish: Yes.

Q185 Mr Jones: How do you feel about the provisions in the proposed Bill that, under certain circumstances, information can be divulged to third-party organisations or be subject to court order?

Scott Morrish: I think if you want results that are comparable with those achieved in the airline industry, you need to give healthcare a mechanism for delivering something on the same terms. The tried, tested and proven model in aviation and other sectors has been a bit watered down in the Bill. At the moment, there is a danger. If you look at the PHSO's evidence, they have the power of the High Court. They therefore could access the safe space, which is wrong. The regulators are all angling on sharing information and expecting co-operation from HSSIB, which is wrong.

The AAIB operates on its own terms in the interests of everyone. The HSSIB should be doing the same thing. At the moment, my concerns are that the Bill is not clear about what the safe space is. It certainly has not separated it out effectively from complaints and regulation, and it has further muddled the waters by suggesting that a trust could be empowered to do those things on its own terms. All of that is confusing most people, I think.

Q186 Mr Jones: Ms Redmond, I think your head was static when I asked the question.

Imelda Redmond: I am not as close to the legislation as Peter and his organisation are, and they have pored over it for a long time. What I think people would expect is that learning is gained in the best possible way and improvement is brought about. If that is within the safe space, that is a good mechanism.

I think what we are talking about here is the drafting of some of the legislation, not the learning. I think we would all agree that the learning is the right thing to do, but the drafting of the legislation at the moment cuts the primary actor—the person who wants this investigated—from it. It has happened to them, but the legislation cuts them out and reduces their rights and ability to get redress or conclusion. It is not the concept that is completely wrong, but the way it is drafted and the barriers to people getting access to information when they need it.

Peter Walsh: Certainly, from our point of view, we are all for protecting staff from unfair repercussions. It is just not right and should not be allowed. For us, there are much more meaningful and honest ways of doing that that I have already mentioned. Creating secrecy and preventing disclosure to patients' families will have a negative effect.

Q187 Mr Jones: Forgive me—if I may interrupt. You say “a negative effect”, but surely the purpose of the legislation is to inculcate a culture of learning into the process of investigating incidents in the NHS. You, Mr Walsh, seem to want to go further and to allow the outcome of that investigation to be used, for example, by families or by the patients themselves in litigation, but that is not what the proposed legislation is for. That is not the purpose of this legislation. It was never suggested that it should be.

Peter Walsh: No, of course it is not the purpose of the legislation. We fully support the stated intentions of the legislation. What the legislation, perhaps a little disingenuously, fails to say is that from the Government's point of view, I suspect, it has something to do with the desire to save the Department of Health money from litigation, among other things—more than it has to do with genuinely protecting staff. I have talked about some practical things that can

be done to protect staff. Why, for example, would you put in a preclusion from people being able to use factual information that an investigation has found about their treatment in respect of what happened and what went wrong? Why would you want to prevent them from using that? That does not help staff.

As I am sure most of the Committee know, in the small number of cases that go to litigation—many people do not want to go near litigation—one of the unintended consequences of this is that it harms people’s access to justice. When people take action against NHS treatment in clinical negligence actions, it is generally against the NHS trust corporately. It is not against individuals. That element of the Bill, for example, has got nothing to do with protecting the individuals. It is about stopping people using factual information.

We are not saying that this should be about designing something that helps people. We are just saying that we should stop the legislation undermining fundamental citizens’ rights to access justice, which this would do. It would also be creating a bureaucratic—and costly—nightmare if people know that they will not be able to use the information gleaned from investigations. Let us not forget that we are talking about the local investigations predominantly here. Currently, if you get a serious incident investigation, you can pore over it and decide what you want to do with it. That is the state of play at the moment. If you were being investigated under safe space, it would preclude you from doing that.

Chair: I have got one or two questions on this, but Andrew might want to come in first.

Andrew Selous: Have you finished, David? I don’t want to cut you off in mid-flow.

Q188 **Mr Jones:** There was just one final point that I wanted to make. The same state of affairs prevails—in fact, to a greater extent—in the case of air accident investigations where there could be, for example, many fatalities. Nevertheless, it is generally regarded that that particular system is highly effective in creating a learning culture that actually creates a safer environment in which to fly. Isn’t that what we are aiming at in this legislation: to create a safer environment for people to be treated in our NHS?

Peter Walsh: Absolutely. That is what we all want. It is a question of how we get there. That is where people might differ. The analogies with the air industry are sometimes overplayed. I believe there is a fundamental difference between the personal contract you make when you agree to step on to an aeroplane and the one you make when you give consent to treatment. Also, there is a traditional relationship with patients that we have expected from the NHS: the principle of “nothing about me without me”; the statements in the NHS constitution; and, indeed, the duty of candour about absolute openness with patients and families about their own treatment.

I also argue that why the air industry is safer is not so much about the protection of information as about the culture of the industry itself—the way in which it welcomes people taking part and does not punish them and hang them out to dry in the same way as the NHS does. To some extent, we are comparing chalk with cheese, but in as much as can you draw conclusions, the air industry has a very different way of doing things.

Q189 **Andrew Selous:** I just wonder whether there is not a distinction between the original concept of what the Bill was trying to do, which was around 30 high-level investigations every year that would have national learning consequences for the whole NHS, and HSSIB coming to the individual localised cases. I hope all three of you would agree that if HSSIB stuck to its original intention of 30 or so high-level investigations a year, the learning from which would spread out across the whole of health services in England and perhaps further afield, that would be a good thing that would absolutely protect patients. I hope that all three of you would want to support that. Would we have your assent to that general notion?

Witnesses: Yes.

Imelda Redmond: Absolutely. We need to make the distinction between the national and the local. Here, we are moving backward and forward between the two, but if we said yes to that and put it to one side, if you like—with people's comments on it—and then talked about the local individual organisations separately, that would be helpful.

Q190 **Andrew Selous:** It is also my understanding that the Air Accidents Investigation Branch can do its work without preventing a police investigation coming on afterwards, as is happening with the Shoreham air accident case. In a sense, we can have the best of both worlds, in that we can get this national learning through what HSSIB is trying to do and, if there are police matters that need to be followed through because there is criminal negligence, the Air Accidents Investigation Branch does not prevent the police from going in afterwards and doing their own investigation. Does that not address some of your concerns, if we are sitting at this high level of 30 or so?

Scott Morrish: It is better than that, in the sense that, as I understand it, the AAIB does not prevent anything from carrying on in parallel. All the other investigations carry on in their time and in their way, but AAIB has primacy. It is at the top of the tree. No one else has to wait for it, but the one organisation that might is the coroner.

Peter Walsh: You are absolutely right that there is a huge difference regarding those 30 national investigations that HSSIB is expected to carry out because, by and large, the individual incidents among those investigations have already been investigated locally and the duty of candour has therefore come into play. The problem we all see, I think, is in leaping from that HSSIB position, even if it has safe space—we can argue the toss about how good a thing it is or not. The main concern is not HSSIB itself and those national thematic investigations, but allowing trusts to operate under the so-called safe space.

Q191 **Chair:** Why do you think the Secretary of State has felt the need to introduce this duty of candour and the freedom to speak up guardians? Why has that been necessary?

Scott Morrish: I regret that either is necessary and I fear that both are an attempt to address the problems that are real and experienced, and lived day in, day out. I do not think they are sufficient in themselves. In the long run, safe space in this particular context and the learning that can come through HSSIB will have a far greater effect, but what is really needed is different regulation with different goals, better leadership and better governance.

Q192 **Chair:** Mr Walsh, why do you think it is necessary to have them?

Peter Walsh: Looking back over the 30-odd years that my charity has been operating, we put lots of evidence in front of lots of Secretaries of State before Mr Hunt agreed finally to bring in the duty of candour. Of course, that was greatly informed by various big scandals, including—

Q193 **Chair:** Okay, but why don't people speak out?

Peter Walsh: There are two elements: there is the speaking out element, and there is the being honest element.

Q194 **Chair:** But why aren't people honest, or why don't they speak out?

Peter Walsh: One of the reasons why people are not honest is that they are scared. They are all the same reasons why people do not speak up, but another reason is that the system tolerated dishonesty. There was no rule or regulation that outlawed dishonesty, just fluffy guidance.

Q195 **Chair:** People were scared of what?

Peter Walsh: They were scared of how their employers were going to treat them. Perhaps they were scared of disciplinary action.

Q196 **Chair:** So what changes under the duty of candour?

Peter Walsh: The duty of candour means that you cannot make excuses about why you are not open.

Q197 **Chair:** Okay, but what happens if you are candid and your employer doesn't like it, or your regulatory body doesn't like it, as we have seen in certain sub judice high-profile cases?

Peter Walsh: What needs to happen, as I have already said, is that people are protected from that behaviour.

Q198 **Chair:** How do you protect them?

Peter Walsh: Not by making information that is peculiar to the patient or family secret, but by creating a genuine safe space, by having regulatory powers for the freedom to speak, a guardian, and legislation for whistleblowers to genuinely protect them.

Q199 **Chair:** Unless they are protected by a safe space, how can they be protected?

Peter Walsh: This safe space is only a prohibition on sharing information.

Q200 **Chair:** You have made that point. Let us look at a different angle to this: who or what, in this Bill, is the safe space intended to serve?

Peter Walsh: The stated intention is to protect staff. If I am perfectly honest with you I suspect that there is another motive here as well, which is really given away to some extent first through the private discussions I have had with the Secretary of State and speeches he has made, in which he has alluded to litigation being one of the things he is concerned about. Secondly, clause 33(2)(a)—the one that says that even when you get the findings of fact,

where they are anonymised, it is not about protecting staff; you are not allowed to use findings of fact in civil proceedings—leads me to suspect that someone is thinking, “We’ll cut down the number of claims that people are able to make.”

Chair: You are shaking your head, Mr Morrish.

Scott Morrish: I think that is extremely cynical. Good leadership and good governance depend upon limiting any kind of harm, amongst other things, including things that could become negligence claims. The greater good is served by increasing patient safety. We all benefit from having a happy, confident workforce, and the safe space is specifically designed to address a deficiency in the current system that comes from misguided regulation, weak leadership and the political ebb and flow of what happens to be possible at any moment in time.

Peter Walsh: At HSSIB level.

Scott Morrish: The objective is to change culture throughout the NHS. It has to start somewhere, and 30 high-level investigations is as good as any place that has been suggested.

Q201 **Chair:** Can you think of any safety investigation body that has protected somebody from the consequences of culpable negligence?

Scott Morrish: It cannot. It is not possible.

Q202 **Chair:** Neither can I. Given that clause 2 is about “investigating qualifying incidents” for the “purpose of addressing risks to the safety of patients by facilitating the improvement of systems and practice”, that seems to be the purpose of the safe space, and it is not for the purpose of blame, civil or criminal liability and so on. The safe space seems to have been tailored for this purpose. What is it that you oppose in that objective for the whole Bill?

Peter Walsh: I have got no objection to the objectives. We are talking about what the Bill actually does. For example, with respect, Scott, the draft Bill itself does not specify any limitation on information that is restricted.

Chair: But if the information could be used to blame the person giving the information, why is that going to be any better than the duty of candour or the protection afforded by the freedom to speak up guardians? The duty of candour does not protect somebody from saying something that could get them prosecuted.

Peter Walsh: I suppose what we are doing is changing the goalposts. The current position is that there is a fundamental principle that the NHS and the Government are signed up to, which is that they believe in full openness and honesty with patients and families—full stop. It is not conditional on whether those staff can feel confident that their employers and the regulators and the Department of Health and Social Care will treat them properly, as they should do, but there is a fundamental point that we will always get the truth.

Q203 **Chair:** But nobody is obliged to incriminate themselves.

Peter Walsh: That is a different branch of law. I am not sure about that.

Q204 Chair: If somebody says, “I am sorry; I am not going to say anything because I feel I might be incriminating myself,” until you get them in front of a court or, funnily enough, into a safe space, you cannot get them to say anything. That is why the policeman says, “You are not obliged to say anything that may be used in evidence against you.”

Peter Walsh: Yes, but there are exceptions in the Bill for that sort of scenario.

Q205 Chair: That is why the safe space exists.

Peter Walsh: When you look at the different exceptions, there are all sorts of bodies for whom there are exceptions in different circumstances—quite rightly, because the kind of situation where there is a dangerous health professional is one you might want to deal with.

Chair: This has been extremely interesting, and I am so glad that you have raised the concerns you have as clearly as you have. I think we take away from this the conundrum that we have the duty of candour, which seems to be at odds with the consequences of the safe space, in your mind. We have taken that on board. Can we move on? Mr Selous, your next question.

Q206 Andrew Selous: Turning it around a bit, from the point of view of staff, I wondered if any of you had any experience of patients and families being reluctant to speak openly.

Peter Walsh: We help 3,000 people a year and have done for more than 30 years. I do not know where the part of the Bill and the background information that suggests that this is about protecting patients’ information has come from, because I have not heard it from any of the families or people that we help and advise. There are protections in the current system for their information to be treated respectfully and so on.

Q207 Andrew Selous: So you do not see safe space as supporting patients to be more confident, other than perhaps the issue that we just talked about—those 30 high-level cases where they think it will go into national learning.

Peter Walsh: Quite the opposite. I talked to patient safety investigators the other day and said, “How is it going to work when you explain to the patient or family, who are meant to be at the centre of the investigation in those local investigations, that you are prohibited from sharing information with them?” People are not going to feel in any way safeguarded or better about the fact that there is some restriction on sharing information about them introduced by this legislation.

Scott Morrish: I would give a very different perspective. I am somebody who did not want to complain. Even though I spent five and a half years in the complaints system, I did not want to complain, and one of the reasons was that I did not want the adverse consequences to impinge upon the welfare of all the staff who I know tried to help my son. I would have been enormously grateful if you could have given me a space in which I could say what I thought had happened without it being framed either legally or in the form of a complaint, because the one thing I really did not want to do was hurt good people. They did not mean for my son to die. He died because of a whole stack of mistakes and it was not one person’s fault, but the

system does not have the capability of dealing with anything subtly, and it certainly cannot cope with that. The only thing it has is a complaints form, and if that fails, some people will then turn to legal consequences. I think the vast majority of people who would benefit from this are people who will never end up sat somewhere like this. They will be quiet. They may be timid. They may be afraid to do all sorts of things, but their need to be heard and to have a safe space in order to do that is at least as real.

Andrew Selous: That is a very interesting perspective. Thank you very much.

Peter Walsh: Can I just give a slightly different perspective on that? I agree with the principle that Scott is talking about and we have heard from other people as well, but, currently, serious incident investigations are not designed with establishing blame or liability in mind. They are patient safety investigations. They are not carried out consistently well. That is the problem.

Q208 Chair: Is not part of the problem that they are very often conducted by people who are trying to avoid blame and litigation?

Peter Walsh: That is why it is a good thing that we have something like the HSSIB, but we also need the quality of those local investigations brought up to a very high standard. The point I was making is that patients do partake in those investigations now. Yes, they could be better, and patients could be involved more, but you do not have to make a complaint or a claim to contribute towards a patient safety investigation. In fact, our initial advice to people is, “Help the NHS. Come up with the right terms of reference. We’ll help you with that. Have a look at the investigation evidence as it emerges. Play a role in assessing that and advising and taking part in the investigation.” Where things are done well, that works now.

Q209 Chair: Anything to add, Imelda Redmond?

Imelda Redmond: My perspective is more that of the general public. I am afraid that the general public say to us exactly what Scott has said. They do not want to get caught up in this terrible complaints process where you spend your life going from one step to the next, not really getting resolution, and then going on through the ombudsman, which gets protracted. There is a real problem in the way that things get resolved in the NHS at the moment. I think what people want is, as Scott described, a place where they can go and honestly have that conversation and get to resolution. I come back to the issue of what you do and do not share with the families, which is about the drafting of legislation rather than the principle. My honest view, from years of working in advocacy-type organisations, is that people want to solve the problem and not let it happen again. They do not want process, process and more process. It is a complicated issue.

Q210 Andrew Selous: Moving on from that, is there any way that the provisions in the Bill could be improved to meet the expectations of patients and families?

Imelda Redmond: I am not into the Bill enough, but I would more than happily go away and look, from the knowledge we have in our organisation, at where it could be strengthened.

Q211 Chair: That would be very helpful. Anybody else?

Scott Morrish: I would urge that as a whole you look for proper independence so that we can all be assured of objectivity. Make sure that that whole-system span is there, so we do not bump against the wall of a silo.

Q212 **Chair:** So you are worried about its independence under the Bill.

Scott Morrish: I am worried about several aspects. The big one is safe space locally and accrediting that—just take it out. Independence is not clear enough at all. I have confidence in the current Secretary of State and the current chief investigator, but we do not know who will follow. In the past there have been people in positions of power who are not quite so interested in patient safety. I want to be protected against a recurrence of people of that view point.

Also, we have not even talked about compulsion yet. Another reason you need safe space is because the idea, certainly within AAIB, is that you are compelled to participate because it is in everybody's interests to make sure that we have safety. That is why we need safe space. You are taking away their right to silence. You are saying, "You don't have a right to silence. In the interests of everybody's safety, you must co-operate, and there are really serious consequences for non-co-operation." That is another very good reason for safe space, and for keeping it high level and not taking it down to trust level.

Peter Walsh: I totally agree with Scott. Get rid of the local investigations element of it altogether and concentrate on HSSIB and making it as effective and powerful as possible. In terms of the controversial area of safe space, a solution was offered by the expert advisory group on the formation of HSSIB. What they recommended was, if you like, a bit of a compromise, saying, "Yes, let's have a safe space, but all information relevant to what happened to the patient or family member must be shared with the patient or family member, who are then free to use it as they wish." On all other elements, they were kind of saying, "Fine."

Chair: We are definitely going to pursue that proposal with other witnesses.

Q213 **Mr Jones:** Returning to the safe space, we have touched on this point previously but, as you know, information gleaned in safe space can, at the discretion of the investigators, be divulged to regulators. What is your view about that? Do you think that is appropriate or not?

Scott Morrish: Again, I would ask you to go back to the AAIB model, which is tried and tested and proven to work, and mimic what they do. It is the very best starting place you can come up with for health. Anything else that deviates from that is a gamble. My concern is that if you leak information via one route or another, be it to the PHSO or to regulators or anybody else, it is not a safe space. As soon as word gets out, it is redundant. So think very carefully before you do anything that compromises it.

Peter Walsh: I would say that there are some absolutely sensible and necessary exceptions where people should share information with appropriate bodies. Clearly, if someone is a danger to patients, it would be madness to say: "We can't share this information with anyone". HSSIB has not got any powers to deal with it itself, so it has to be right that in

exceptional circumstances information is passed on to regulators or other bodies, if it is strictly in order to protect patient safety.

Q214 Mr Jones: Could you give me an indication of the sort of circumstances where in your view it would be proper for that information to be passed on?

Peter Walsh: Let's imagine that an investigation finds something out—it is usually a system error, we all know that, it is rarely all down to individuals. In some cases you uncover an incident where one or more health professionals are unfit to practise and are a danger to their patients. When that becomes apparent, I would say it is a no-brainer. Surely that information would have to be passed on to people who can deal with it. There is no point in having a so-called safe space that allows dangerous practice to continue.

Imelda Redmond: I would agree with that. I do not know enough about the aviation industry, but I am sure if they found that a case was about human error consistently—it was about a practitioner such as an engineer or a pilot—and they were not learning, you would not just say, “We can't do anything about that one”.

Peter Walsh: I think the difference is that the AAIB can deal with it itself, whereas HSSIB could not.

Scott Morrish: If there are concerns about gross negligence or malicious behaviour or criminal action, they are passed on to the relevant authorities, which is different from sharing what exists within the safe space. Concerns can be passed on, therefore all those other agencies can do whatever is necessary and whatever they should do. As I said before, it does not constitute either immunity or impunity. It is just their statement, but obviously all other sensible precautions should be taken.

Chair: It is like freedom of speech in Parliament. We can say what we like in Parliament, but if we say it outside, we are liable. It seems to me that if an investigator or regulatory body outside HSSIB is pointed in the right direction and can ask the questions, they will make up their mind whether the suspect is guilty or not on the basis of the information that is given or not given.

Q215 Mr Jones: You mentioned gross negligence manslaughter. Presumably you have seen the report of the Williams review. Would you like to make any observations as to how you feel its recommendations will affect patients and families who may have been affected by serious medical incidents?

Chair: Imelda Redwood? I am not putting you on the spot—that is not the objective of the exercise.

Imelda Redmond: Absolutely. The issue is that there are two answers. What patients and families would say is that if there is consistent negligence, then people should be held to account.

Chair: Anybody else?

Peter Walsh: I would say the Williams review recommendations are welcome. Largely, this is a question of awareness and education. These cases are very rare. There has been some

dangerous scaremongering and misinformation about one or two notable cases recently that have got things out of proportion. In as far as it goes, I think the recommendations are sensible, there is better awareness, and it should be only the very highest, worst type of behaviour that ever gets anywhere near a criminal investigation, let alone a criminal prosecution.

The curious situation where the GMC overturns the findings of an independent tribunal has been a curiosity that people have had for many years. Why have an independent tribunal if the regulators are going to get involved and change it anyway?

Scott Morrish: I haven't read the report—I will read it; I have been very focused on this—so I am not going to comment.

Mr Jones: We quite understand.

Chair: Do send us your reaction to that, any of you, if you would. My Lords, you are still here.

Baroness Billingham: It's the wind-up speeches.

Chair: Please ask any questions you would like now.

Q216 **Baroness Watkins of Tavistock:** Shall I ask the accreditation question? How do you feel about trusts being accredited to undertake local investigations and investigate each other? I think you have alluded to that.

Imelda Redmond: I think it would undermine public confidence in the process.

Q217 **Chair:** It occurs to me that it would be much easier to compare the safe space investigations conducted by HSSIB with the non-safe space investigations conducted by the trusts to see which is going to lend which the improvement. In a way, that is a good way of experimenting, Mr Walsh, with your concern. The very limited number of investigations done by HSSIB at the outset will give us an opportunity to see how this works and what needs to change.

Peter Walsh: Indeed. It certainly makes sense to see how that goes first, but also they are different sorts of investigations in that they have normally been investigated locally anyway. I think you are right, Mr Jenkin.

Scott Morrish: Just to follow that up, I am not aware that any other industry that has safety investigations does that—for example, aviation does not accredit that power to any of the airlines. Go and find out why not.

Q218 **Lord Kirkwood of Kirkhope:** Can I ask a quick question about applying the same kinds of difficulties on getting a measured outcome for safe space, to professional reflections? You will probably all be aware that fitness to practise systems are encouraging people to do 360° reflections with peer groups and all the rest of it. It is a very important development and seems to be helpful in an educational professional development sense. Do you have the same worries about that as you do about safe space?

Scott Morrish: I don't know how you can practise professionally without the ability to reflect properly, therefore I would question anything that compromises that ability. I do not think you can function well or develop or grow without the ability to do that, so the system should put in place safety around that information if it is committed to paper.

Peter Walsh: I am nowhere near as worried about that as I am about the safe space provisions in the Bill, so long as it does not override the professional's own professional duty of candour or the statutory duty of candour.

Chair: We have got that.

Imelda Redmond: I think it makes perfect sense in any learning organisation in any field.

Q219 **Baroness Watkins of Tavistock:** If we accepted your premise that local trusts should not be involved, and if safe space investigations run by trusts are not the answer, how could HSSIB support the improvement of local investigations?

Scott Morrish: The initial advice from the advisory group was that one of its tasks should be specifically to develop methodologies and to train people at grassroots level to do those very things. That is exactly what it should do, which is very different to accrediting safe space. It is also very different from what is happening with maternity. It is not a quick fix, but in the long run that will create the different environment by providing better answers for people at the beginning. It needs to be partnered with the change in the tone of leadership and the style of regulation. If we put them all together, we have a safe space that we can all go out and work in and receive care in.

Peter Walsh: I agree: leading by example, and training. They have a lot on their hands at the moment but eventually they should be able to roll out training with local trusts and so on.

Q220 **Baroness Watkins of Tavistock:** You would obviously want that training to be properly accredited with certain people.

Peter Walsh: Yes, so a different sort of accreditation, not that for doing safe space investigations. One thing about the local investigations is that it is very notable that when HSIB was asked to do the maternity investigations, which it has now started, because they are local investigations and of a different nature—about getting to the bottom of what happens in individual incidents, which of course patients and families have such an investment in and a desire to know fully about—HSIB and its chief investigator Keith Conradi were very clear that that type of investigation in no way lends itself to the safe space approach. One thing we need to bear in mind, of course, is that if we create the safe space for HSSIB we have to be careful that the legislation does not allow that then to extend to doing those types of investigation.

Chair: Is there anything else? I feel that your lordships have been given short shrift because we were expecting you to be taken from us. Do feel free to add anything else you have.

Q221 **Baroness Eaton:** This is almost a minor point, but it is a serious one. In all the discussion we have had about patients and families pursuing things, the one thing we have not mentioned is the harrowing nature of doing so. I am sure that Mr Morrish

will recognise that there are many situations in which families just cannot face going through the process. In any system we are investigating, we should be able to make it easy, to understand how difficult and harrowing such a situation is.

Scott Morrish: Definitely. People talk about the option of complaints or the option of litigation, and for me it was a prison sentence. You should not have to go to prison to find out what happened to your son. I am not free of that yet. The consequences of it run on and affect your whole family and every friendship you have had. That is happening across the country on a random basis because we do not have a safe space in which to do safety investigations and because in all the investigations we have right now—I think Chris Hopson talked about this—there is the need to balance the books within a trust versus the patient’s interest. That is the harshest reality and I know it exists, but as a patient you just want to know and understand, and to prevent it from happening again. If you can create safety investigations that will allow that to happen, you will liberate many of us and take away a lot of the ill feeling that exists right now.

Q222 **Baroness Eaton:** When that is not possible and people look to litigation, it is surprising the number of people who cannot face it and do not do it. I am one of them.

Peter Walsh: In fact, most people do not want to. When people start asking us about that it is usually because they have not had openness and honesty and they are frustrated and angry.

Q223 **Chair:** With almost perfect timing, I thank you very much indeed for appearing before us and particularly for the burden each of you carries in your different ways, representing the people in great distress that Baroness Eaton refers to. It is a great service to patients that you conduct. You have served their interests very well by appearing before us today. Thank you very much.