Introduction

1. The Equality and Human Rights Commission has been given powers by Parliament to advise Government on the equality and human rights implications of laws and proposed laws and to publish information or provide advice, including to Parliament, on any matter related to equality, diversity and human rights. We hope that our submission will help inform the Committee’s recommendations to the UK Government on the content of this Bill.
2. In 2015, the Commission called on the UK Government to set up an independent body to investigate incidents leading to patients dying from non-natural causes in psychiatric hospitals, to mirror the remits of the Prisons and Probation Ombudsman and the former Independent Police Complaints Commission in relation to non-natural deaths in other state detention settings.¹

3. In June 2016 the UN Committee against Torture (CAT)² identified the following key issues for the UK Government to address:

- ill-treatment of patients receiving healthcare services, including concerns about the inadequacy of measures taken to ensure effective implementation of the recommendations in the Mid-Staffordshire NHS Foundation Trust Public Inquiry reports; and
- the number of deaths in mental health detention and the measures taken to prevent such deaths in the future.

4. We therefore welcome the proposed establishment of the Healthcare Services Safety Investigation Branch (HSSIB) and the draft Bill that will give it statutory status and powers. We agree with the Bill Committee’s Chair that the work of HSSIB could ‘save 1,000s of lives and £billions for the NHS in the years to come’³ but we think that it will only do so if it is set up in a way that fully complies with the positive duties imposed by the Human Rights Act 1998, reflects international human rights standards, and builds on lessons learnt from past experiences in the NHS and in other sectors.

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² Convention against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment. 57 Session (18 Apr 2016 - 13 May 2016) – see UK section. Available at http://tbinternet.ohchr.org/_layouts/treatybodyexternal/SessionDetails1.aspx?SessionID=1011&Lang=en.
Summary of recommendations

5. We recommend that the Bill be amended to:

- Ensure that HSSIB can demonstrate that it conducts investigations which are fully independent of those it investigates;
- provide HSSIB with additional powers to encourage transparency and accountability and to oversee the implementation of its recommendations by NHS organisations;
- ensure that the right balance is struck between (a) the creation of a ‘safe space’ within which HSSIB investigations can be conducted and (b) the rights of patients and/or their families to be informed of the findings of the investigations and the possibility for public scrutiny;
- ensure that NHS Trusts cannot be accredited to conduct investigations which must comply with Articles 2 and/or 3 of the European Convention on Human Rights (ECHR) or internal investigations within their own Trust; and
- add HSSIB to the list of organisations subject to the public sector equality specific duties and to ensure that it uses equality information to better inform its work, to set equality objectives, and to monitor whether its recommendations led to improvement of patient safety for all.

General issues

6. The Bill establishes HSSIB as independent statutory body, with powers to conduct investigations into incidents or accidents within the NHS which appear to evidence risks affecting patient safety. Some of the incidents for which the Bill gives HSSIB responsibility for investigating are the subject of state obligations under domestic legislation and international human rights standards.

7. Articles 2 and 3 of the ECHR place an obligation on the State to ensure that an independent official body carries out an effective public investigation into any death for which the State might be responsible.

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and into any incident where there are clear indications that serious ill-treatment may have occurred. Case-law makes it clear that there should not only be a ‘lack of hierarchical or institutional connection but also a practical independence’ between the investigator and investigatee.\(^5\)

8. Article 12 of the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) also requires State parties to proceed to a prompt and impartial investigation wherever there is reasonable ground to believe that an act of torture has been committed. The Committee against Torture clarified that this requirement also applies to other forms of cruel, inhuman or degrading treatment that might fall short of torture and to private settings in circumstances where the State knows, or has reasonable grounds to believe, that torture or ill-treatment is being committed in such settings\(^6\).

9. In addition, Article 14 of the CAT requires State parties to ensure that victims of torture or ill-treatment have a right to obtain redress. The Committee against Torture has clarified that the right to obtain redress includes the right to satisfaction and guarantees of non-repetition\(^7\).

10. Despite these requirements, many families and external organisations have raised concerns\(^8\) about the independence of investigations carried out within the NHS. Other evidence\(^9\) shows that serious incident investigation reports conducted within the NHS focused on staff omissions or failures to follow policies or procedures and did not identify the underlying system or environmental factors that led to things going wrong.

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\(^5\) Al Skeini v UK (2011) 53.


11. To comply with domestic legislation and international standards, and to command the confidence of patients, their families and of healthcare professionals, it is vital for HSSIB to be and be seen to be a fully independent body that conducts effective and impartial investigations. To this effect, we recommend that:

- Clause 2 of the Bill, which sets out the detail of HSSIB’s investigative function, should be amended to confirm that HSSIB is responsible for conducting independent investigations into all incidents which result in serious ill-treatment and deaths for which the State may be responsible, to identify systemic failings and to make recommendations to minimise the risk of similar incidents happening again in compliance with the State’s duties under Articles 2 and 3 of the ECHR and under Article 12 of the CAT.

- Schedule 1 of the Bill, which sets out the procedure for appointing key officers of HSSIB, should be amended to provide that:
  
  i. while the Secretary of State is responsible for appointing the Chair, all other non-executive appointments should be the responsibility of the Chair and the appointments of the Chair and other non-executive members should be subject to parliamentary scrutiny; and

  ii. persons appointed to the positions of HSSIB Chief Investigator, executive members, non-executive members and lead investigators must never have worked for the NHS or the Department of Health and Social Care. Similar restrictions apply to appointments to the new Independent Office for Police Complaints.¹⁰

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¹⁰ The website of the IOPC (formerly known as the Independent Police Complaint Commission) explains that ‘By law, our Director General can never have worked for the police. Also none of our executive team, regional directors or our Director for Wales have worked for the police. See https://policeconduct.gov.uk/who-we-are/our-people. Further, in her recent review of deaths and serious incidents in police custody, Dame Angiolini recommended that the IPCC to phase out ex-police officers as lead investigators and to use them only as formal consultants or training sources to enable the IPCC to ‘achieve a mature and patent independence from the influence and culture of those it investigates’. See Home Office, 2017. Report of the Independent Review of deaths and serious incidents in police custody. Available at https://www.gov.uk/government/publications/deaths-and-serious-incidents-in-police-custody.
12. In addition to protecting the independence of HSSIB investigations, such amendments will also demonstrate Government’s commitment to ensuring that where people suffer serious harm or death in NHS settings, the same level of independence in the investigation process is guaranteed as when people suffer serious harm or death in police custody.

13. Finally, we recommend that HSSIB’s remit should extend to private hospitals in light of the recent concerns raised by the Care Quality Commission (CQC) about patient safety and leadership in these hospitals and given the international obligations of the State under the CAT as explained in paragraph 3.

Establishment and powers

14. The Secretary of State for Health acknowledges that the priority for patients and families is for the NHS to learn from deaths and/or serious incidents which are the responsibility of the State to ensure that it does not happen to anyone else. We note, however, that ‘many carers and families do not experience the NHS as being open and transparent and that opportunities are missed to learn across the system from deaths that may have been prevented.’

15. The Bill provides the opportunity to create a much-needed mechanism for not only investigating incidents, but also for providing oversight of the steps which NHS Trusts take to improve and learn from past failings. In order to ensure that HSSIB meets this need, we recommend that clause 7 should be amended to include a specific requirement for NHS Trusts to disclose to HSSIB all information on the actions they have taken/not taken as a result of previous:

- patient safety alerts issued by NHS Improvement that are relevant to the incident investigated by HSSIB;

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• internal and external investigation reports\textsuperscript{14} into similar incidents that happened in the care of the trust being investigated by HSSIB; and
• concerns\textsuperscript{15} raised by patients, families and staff working at the NHS Trust being investigated that relate to similar incidents.

16. We also recommend an amendment to Clause 34 so that relevant NHS organisations are not only required to publish a report on the actions they are planning to take to respond to HSSIB recommendations but also on the actions they have taken thereafter in order to implement those recommendations and the impact such actions have had on patient safety. We suggest that Clause 31(6) should be amended to require HSSIB to specify in its investigation reports the frequency and number of follow-up reports which it requires from the NHS organisation in question. Follow-up reports should be evaluated by HSSIB, to inform its own reporting activities, and should be made publicly accessible so that the steps which NHS organisations are taking to improve patient safety and their impact can be subject to public scrutiny.

Safe space

17. Part 4 of the Bill provides a framework for restricting disclosure of information during an investigation so as to protect the ‘safe space’ which we agree is an important factor for ensuring the effectiveness of investigations which are compliant with Articles 2 and 3 of ECHR.

18. There is a balance, however, to be drawn between the prevention of disclosure of information during an investigation and in the investigation report, and the rights of patients and/or their families to be involved in the investigation and for the investigation and its results to be open to public scrutiny.

19. We are concerned that the current clause 28 does not achieve the right balance in relation to investigations into deaths and serious ill treatment. We recommend that the drafting is revisited with this in mind.

\textsuperscript{14} E.g. Coroners rule 43 reports to prevent future deaths; public inquiry reports including in relation to homicide committed by NHS patients; serious incident investigation reports; informal reviews conducted on patient safety incidents that do not meet the threshold for serious incident investigations.

\textsuperscript{15} Through the Trust complaints department or safeguarding team or through the Trust freedom to speak-up guardians.
One option might be for clause 31(5), for example, to be amended to include a presumption of disclosure in the investigation report of all information necessary to ensure that the patient and/or their family understands why the incident occurred and the steps which are required to ensure that similar incidents do not happen in the future.

**Accreditation**

20. Clauses 20 and 21 of the Bill provide that HSSIB may accredit NHS Trusts to conduct safe space investigations in other NHS Trusts (external investigations) and, in some cases, their own Trusts (internal investigations). We understand the rationale behind the proposed accreditation process to be ‘to improve local safety investigations and spread a just culture of learning within the NHS as set in the ‘policy background’ section of the Bill’\(^{16}\).

21. We note, however, that for the reasons set out above, NHS Trusts are not perceived to be sufficiently independent to be able to conduct investigations into deaths and/or ill-treatment for which the State may be responsible in compliance with domestic human rights legislation and international human rights standards. Further, while the NHS has endeavoured to learn from patient safety incidents by conducting internal investigations for a number of years\(^ {17}\), evidence shows that:

- serious incident investigations conducted by NHS Trusts were generally of poor quality, ‘completed to satisfy a process, not to improve patient care’ and that time was ‘spent investigating very similar incidents which fail to generate new learning’\(^ {18}\).

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most serious incident investigation reports did not include recommendations and actions that could reduce the risk of the similar incidents happening again.  

22. In light of the above, NHS Trusts should only be accredited to conduct external investigations into incidents for which compliance with Articles 2 and/or 3 of the ECHR is not required. We therefore recommend that:

- Clause 2 should be amended to include a definition of ‘qualifying incident’ with two parts: (a) incidents that lead to deaths for which the State may be responsible or where there are clear indications that serious ill-treatment may have occurred must be independently investigated by HSSIB; and (b) all other incidents which must be investigated at the local level by an accredited NHS Trust.

- Clause 21 providing for internal investigations is deleted.

23. We further recommend that the Bill should impose a duty on (a) Medical Examiners and Coroners to report any death for which there are reasonable grounds to believe that the State may be responsible to HSSIB; and (b) NHS Trusts to report to HSSIB any incidents for which there are reasonable grounds to believe that serious ill-treatment has occurred. This would align with a similar reporting duty that applies to the police.

24. Finally, we recommend that the Bill should clarify that patients and families will be able to request HSSIB to conduct an investigation.

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20 Medical Examiners are now due to be in post across England no later than April 2019. See Lord O’Shaughnessy’s announcement at [https://hansard.parliament.uk/Lords/2017-10-18/debates/F1C7369A-F470-4730-B795-06C69BF3C85A/MedicalExaminersAndDeathCertification](https://hansard.parliament.uk/Lords/2017-10-18/debates/F1C7369A-F470-4730-B795-06C69BF3C85A/MedicalExaminersAndDeathCertification). Medical examiners are expected to be responsible to scrutinise and confirm the cause of all deaths that do not need to be investigated by a coroner before a medical certificate of cause of death is issued; explain the certified cause of death to relatives and give them the opportunity to raise any concerns they might have about the care provided to the person who has died; and to report the death to a coroner where appropriate.

21 All deaths and serious injuries during or following police contact must, by law, be referred to the IOPC. When the IOPC receives a referral from a police force, it decides if an investigation needs to take place. The IOPC is responsible to carry out independent investigations into the most serious and sensitive incidents and allegations involving the police. See IOPC, 2018. A guide to IOPC independent Investigations. Available at [https://www.policeconduct.gov.uk/sites/default/files/Documents/Investigations/our-investigations-a-guide-to-IOPC-independent-investigations.pdf](https://www.policeconduct.gov.uk/sites/default/files/Documents/Investigations/our-investigations-a-guide-to-IOPC-independent-investigations.pdf) and IOPC, 2018. How we investigate when someone has died – a brief guide. Available at [https://www.policeconduct.gov.uk/sites/default/files/Documents/research-learning/a_brief_guide_to_investigations.pdf](https://www.policeconduct.gov.uk/sites/default/files/Documents/research-learning/a_brief_guide_to_investigations.pdf).
where the Medical Examiner, Coroner and/or an NHS Trust has failed to make a report to HSSIB in line with the duties proposed above. This is to ensure that the new system is set to ensure that all potential qualifying incidents are reported to HSSIB\textsuperscript{22}.

25. While the above proposals will result in HSSIB conducting more investigations than the original proposal envisages,\textsuperscript{23} there would be a corresponding reduction in the number of investigations conducted by NHS Trusts which should result in these proposed amendments being cost neutral. Further, if the system operates as intended, the number of investigations carried out by both HSSIB and NHS Trusts should reduce over time as the recommendations made in each investigation report are implemented.

### Reporting

26. Clauses 31 and 32 set out the requirement for HSSIB to publish reports of findings and recommendations to improve patient safety in a specific area of the NHS and/or for a particular cohort of patients. We welcome this proposal which will facilitate public scrutiny of HSSIB’s work and the extent to which NHS organisations are improving as a result of its influence. We also anticipate that the amendments to clause 34 which we have proposed in paragraph 9 above, which would require further follow-up reporting from NHS Trusts to HSSIB, will ensure that HSSIB’s reports will present a comprehensive picture of the improvements taking place as a result of its work.

\textsuperscript{22} For instance, the Confidential Inquiry of 2010-2013 into premature deaths of people with learning disabilities identified deaths that should have been, but were not, reported to mandatory review processes, including safeguarding reviews and to the coroner. See Heslop P, Blair P, Fleming P, Hoghton M, Marriott A, Needleman D, Russ L. (2013) Confidential Inquiry into premature deaths of people with learning disabilities. Bristol: University of Bristol. Available at \( \text{https://www.bristol.ac.uk/media-library/sites/cipold/migrated/documents/fullfinalreport.pdf} \).

\textsuperscript{23} HSSIB was set-up in April 2017 to conduct up to 30 investigations per year into incidents raising significant patient safety issues. In November 2017 however, the Secretary of State for Health announced that HSSIB would investigate all stillbirth, early neonatal death and severe brain injury cases as part of the new Government’s strategy to halve the rate of such incidents by 2025. As a result, HSSIB has recruited a significant amount of staff to conduct investigations into 1,000 incidents leading to avoidable maternal or baby death or serious harm.
27. There is currently a lack of robust data on whether people with particular protected characteristics disproportionately suffer serious ill-treatment and deaths for which the State may be responsible in particular NHS settings.

28. In light of the above, we recommend that further obligations should be imposed on HSSIB to ensure that equality considerations are prioritised in its work. We recommend that schedule 2, which amends Part 1 schedule 19 of the Equality Act 2010 (public authorities to which the public sector equality duty applies) should also amend Schedule 2 of the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 201724 to include HSSIB as a public authority required to publish: (i) information to show their compliance with the general public sector equality duty including information on their employees25 and persons affected by their policies and practices who share a protected characteristic26 under the Equality Act 2010, and; (ii) specific and measurable equality objectives.

29. We think that access to such equality information on patients suffering serious ill-treatment or deaths for which the State may be responsible will enable HSSIB to:

- inform the evidence-gathering process; and
- track whether its recommendations lead in time to a reduction of avoidable death and severe harm among patients with particular protected characteristics.

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25 If a listed public authority has at least 150 employees including those on secondment and fixed-term contracts.

26 The protected characteristics under the Equality Act 2010 are age, gender, gender reassignment, marriage and civil partnership, religion or belief, disability, sexual orientation and maternity and pregnancy.