Witness Name: Rosie Benneyworth
Statement No.: [3]
Exhibits: [2]
Dated: [21/01/25]

THIRLWALL INQUIRY

WITNESS STATEMENT OF DR ROSIE BENNEYWORTH INTERIM CHIEF INVESTIGATOR HEALTH SERVICES SAFETY INVESTIGATIONS BODY (HSSIB)

I, Dr Rosie Benneyworth, will say as follows:

General Background

- The Health Services Safety Investigations Body (HSSIB) came into operation on 1 October 2023, established by the Health and Care Act 2022, as a fully independent arm's length body of the Department of Health and Social Care.
- Our core role is to conduct independent patient safety investigations, which do not find blame or liability with individuals or organisations across the NHS and in independent settings.
- We want to understand why patients may have been harmed or could be at risk of harm. We take a systems perspective and aim to reduce the likelihood of patient safety incidents occurring. We share learning and support patient safety improvements across the whole healthcare system in England.
- Our investigations are intended to identify risks to the safety of patients and address those risks by facilitating the improvement of systems and practices in the provision of NHS services or other healthcare services in England.
- The purpose of a HSSIB investigation does not include assessing or determining blame, civil or criminal liability, or whether action needs to be taken in respect of an individual by a regulatory body. No individual may be named in a HSSIB investigation report without their consent if they were involved in an incident subject to investigation or have provided information to us for the purposes of an investigation.
- Our investigation reports are not admissible in any civil or criminal proceedings, including employment tribunals or proceedings in front of a regulatory body, unless an order is made by the High Court.

Safety Recommendations Background

- We may issue interim or final investigation reports that contain a statement of findings of fact made because of the investigation and an analysis of those findings. Our reports may also contain recommendations as to the action to be taken by any person as the HSSIB considers appropriate to improve patient safety. Where recommendations are made, we can set a deadline in which to receive a written response; typically, we have provided a response period of three months to recommendation recipients. A person in receipt of a HSSIB recommendation must respond to us in writing setting out the actions they propose to take in pursuance of the recommendations, and we may publish the response.
- Our investigations produce findings that identify where action can be taken to improve patient safety. Findings of our reports are listed in the executive summary and include relevant information discovered by the HSSIB investigation about the safety risk in question.
- These findings in turn help to focus and direct where there may need to be safety recommendations, safety observations, safety actions, or other local level learning to help address the risks to patient safety. These different methods are used to help communicate where safety learning may sit in the healthcare system and help to span a range of recommended action, from national organisations to support that may be offered to 'front line' staff in delivering care.
- Safety recommendations are made to organisations and bodies best placed to take action to address a risk to patient safety at the national level. We do not make safety recommendations to local healthcare organisations. Areas of focus for safety recommendations are typically identified during the investigation. These are then discussed with relevant national stakeholders to best identify which organisation should take ownership of the safety recommendation, the technical wording of how this is presented in the report for maximum impact, and the requirements to respond to the HSSIB safety recommendation once it is made. Typically, organisations are asked to respond within 90 days of the date, the investigation and their response is then published on the HSSIB website.

1. In 2021, HSIB published a thematic analysis of 22 national investigations.

   Investigation report: A thematic analysis of HSIB's first 22 national investigations

This identified the following three recurring patient safety themes:

- Access to care and transitions of care (when patients move between care providers or care settings)
- Communication and decision making
- Checking at the point of care.

2. Within these 22 investigations, 85 recommendations were made. These were analysed and demonstrated that using a categorisation based on principles of safety management systems, supports a more organised approach to making safety recommendations which can make them more effective. It also supports a more integrated approach across a complex healthcare system.

3. In 2024, HSSIB undertook a review of recommendations made in a further 11 investigations, considering 49 safety recommendations made across 20 different national bodies **[RB/1 INQ0108800]**. This review found some action had been taken in response to 29 of these recommendations, a further six had some action underway, and we were unable to confirm if any action had been taken in response to the remaining 14.

4. We found that 21 actions taken met our expectations with good examples of potential impact in relation to the following safety risks:
    - National pathway for diagnosis and management of cauda equina syndrome
    - National standard to address safety issues posed by button/coin batteries
    - Regulatory surveillance of electronic prescribing systems as medical devices
    - National guidance to support effective ward rounds and medication safety
    - National standards for education of ambulance staff in paediatric care
    - National guidance to support decision making for medication management

5. However, in the main, we found that regardless of action being taken, organisations had no mechanism in place to monitor effective implementation, or the ability to understand the impact of the action taken. HSSIB are currently working in partnership with the University of Nottingham, to develop 'impact enablers'. We facilitated an Impact Leaders workshop in October 2024 which was attended by key stakeholders, including NHS England, PHSO, NGO, NHS Resolution, CQC, NICE, PSC and Royal Colleges. An early draft thematic analysis of the feedback from this event is provided to the inquiry **[RB/2 INQ0108801]**

6. HSSIB have also identified repeated safety failure through our work, despite our investigations and recommendations made to the system.

   Examples include:

   - The potential under-recognised risk of harm from the use of propranolol, published February 2020 – this report made seven recommendations focused on updating guidance and information around toxicity, along with guidance for prescribers and oversight in ambulance control rooms. At least two further Coroner's Prevention of Future Death (PFD) reports, published in 2022 and 2023, suggest these recommendations were not implemented effectively and describe persistent safety failures in relation to overdose of propranolol and recognising the urgency required in these cases.
   - Unplanned delayed removal of ureteric stents, published October 2020 – this report made four recommendations, including the need for national standards for monitoring stents. HSSIB were contacted by a family member who lost their relative in November 2024 due to the issues highlighted in our report. It is likely that, had all the recommendations from our report been implemented effectively, this death could have been avoided.
   - The design and safe use of portable oxygen systems – we published our findings in 2018 and have identified this safety issue being cited in further Coroners reports as recently as 2024.
   - Harm caused by delays in transferring patients to the right place of care, published August 2023 – prior to the final report, we published 3 interim reports between 2022 – 2023 as part of this investigation, highlighting key safety issues relating to patient flow and ambulance waits, gaps between health and social care, a lack of accountability framework for patient safety, and poor staff wellbeing. Our final report made four recommendations highlighting the need for an urgent, strategic national response to patient flow, capacity and demand issues. Since the publication of this report HSSIB are aware of at least three Coroner's PFD reports that reference the recommendations made and an urgent need for a 'whole system' response to ambulance and discharge delays.

7. HSSIB has been working with a wide range of national organisations and published a report in September 2024 - Recommendations but no action. This report is an output of the work commissioned by the Department of Health and Social Care (DHSC). At a

meeting of the Arm's-Length Body (ALB) Chief Executives and Chairs in November 2022, identified areas where joint work between DHSC's ALBs would be valuable. A series of workstreams were set up as a result, one of which was around recommendations. The report by HSSIB identified the following key areas:

- Failure to implement actions following recommendations can impact public confidence in the healthcare system and compound harm to patients.
- The 'noise' created by the significant volume of recommendations being made to the healthcare system means that providers struggle to prioritise and implement recommendations, concentrating on those which are addressed directly to the provider, or where there are immediate patient safety risks.
- Some recommendations duplicate or contradict others. The development of a searchable repository which includes recommendations made across the healthcare system may help to reduce this.
- It may reduce the 'noise' and help with prioritisation if organisations refer to each other's recommendations, or group together in support of one organisation's recommendation rather than repeating it. The development of an agreed system to identify recommendations for cross-referencing would assist this.
- There is currently a lack of visibility of ongoing work across arm's length bodies that would enable collaborative working on related workstreams. A searchable repository of ongoing work may assist this.
- Recommendations differ in terms of the evidence on which they are based, and their structure and language. This can affect their relevance and how they are interpreted.
- It is unclear how some recommendations are intended to impact the patient, which should be a key consideration in their development where possible.
- Most recommendations made to the healthcare system are not costed, either in relation to the cost of implementing the proposed actions or their longer-term cost effectiveness. This may affect providers' ability to implement them and means there is a lack of information to support prioritisation decisions.
- Some recommendations may be of limited relevance to certain providers and could promote inequalities by negatively impacting certain patient groups if implemented. However, providers can feel they are not empowered to reject recommendations, especially those related to safety.
- Few recommendations require a formal response from the recipient organisation, and there is a lack of monitoring of the actions planned or taken to address

recommendations. A monitoring system could help to track actions and identify opportunities for escalation where changes have not been made.

8. In addition to the HSSIB report, Imperial College London produced the National State of Patient Safety report which highlighted that '*the most high-profile source of patient safety priorities are the outcomes of major reviews, investigations or inquiries, many of which are triggered by widescale failures in care. In 2024, the House of Commons Health and Social Care Committee commissioned an expert panel to evaluate the Government's progress on meeting patient safety recommendations'.*

9. The Imperial report also highlighted that '*Evidence submitted by the Government identified 508 recommendations pertaining to patient safety from 12 public inquiries and reviews between 2010-2022 – averaging one inquiry and 42 recommendations per year. Occasionally, a tragic case can trigger new guidance and action to prevent future harm, such as the introduction of Martha's Rule following the death of 13 year old Martha Mills, giving families the right to a rapid review of a patient's condition'*. The Imperial report recommends that '*national organisations must agree on a focused set of patient safety improvement priorities for the system to rally around',* which is in line with the HSSIB report Recommendations but no action.

10. Our current investigations into mental health inpatient settings illustrate how, despite national focus, safety risks remain and reoccur. The safety of mental health services is a key national priority; this is demonstrated by the introduction of several NHS strategy documents. But safety concerns for mental health services remain. In January 2023, a rapid review was commissioned due to concerns that the right data and information needed to provide early alerts to identify risks to patient safety in mental health inpatient settings and prevent safety incidents was not available. The lack of information undermines efforts to improve care and keep patients safe. Thirteen recommendations were made including one that states recommendations should be implemented by all parties within 12 months of the publication of the report. The report was published on 28 June 2023. DHSC convened a ministerial led steering group to oversee the implementation of the recommendations, however HSSIB is aware this group has only met once.

11. HSSIB believes without an effective approach to managing safety across healthcare, we will continue to identify repeated safety failure where known risks are not being effectively managed and reduced to an acceptable level.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

Signed: Personal Data

Dated: 21 January 2025

Exhibits

RB1 - Health Services Safety Investigations Body (2025) Summary document outlining impact from HSIB and HSSIB investigations, Internal document.

RB2 - Health Services Safety Investigations Body (2025) Summary of stakeholder discussions about HSSIB position in the health and care landscape, Internal document.