General
Medical
Council

Annex H: Guidance for case examiners and the Investigation Committee on single clinical incidents

Question 1: How much weight should be placed on the outcome of an incident?

In considering any case involving a single clinical incident, the starting point should be for the case examiners to apply the criteria in the main case examiner guidance. The case examiners should consider whether the information about the incident indicates that there may have been a serious failure to meet the standards in *Good Medical Practice.*

When a single clinical incident has resulted in an adverse outcome, including the death of a patient, the case examiner will need to assess it's bearing on the particular case in determining the outcome.

In some cases, the fact that the incident resulted in the death of a patient (or another serious outcome) will be a marker of the doctor's departure from Good Medical Practice. This might arise when the doctor failed to take adequate precautions in carrying out a procedure with a high degree of risk.

On the other hand, it is important that the outcome of the incident should not be considered in isolation. The case examiners will also need to consider the circumstances in which the incident occurred. Case examiners will need to consider whether the doctor's actions fell below what could reasonably be expected of a practitioner at his or her grade and level of experience. For example, the case examiners will need to consider whether the doctor was in a training grade and what, if any, supervision and support mechanisms were in place.

Question 2: When the death of a patient occurs, should the outcome be the determining factor with regard to disposal?

The fact that a clinical incident has resulted in a patient's death will have a bearing on the consideration of the case. However, the death of the patient needs to be considered along with all the other factors. Again, the case examiners will need to follow the main decision-

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making guidance to assess whether the standard of the doctor's practice was acceptable in the circumstances.

The fact that the patient has died will undoubtedly mean that the incident needs to be properly investigated, normally under local procedures. In many cases, this will be needed so that a clear explanation of the circumstances can be given to the next of kin. Very often, other sources of information, such as the report of an Independent Review tribunal may shed light on the incident. The case examiners should ensure that any local inquiry has been sufficiently rigorous before relying on this when concluding a GMC investigation. In some cases, case examiners will need to supplement any information already collected with an expert report or other information. Case examiners may also need to consider whether an assessment of the doctor's performance is required.

Question 3: What should the Case Examiner consider in cases in which the incident was serious but the death of a patient did not occur.

There will be some cases which do not result in the death of a patient, but which, nonetheless, raise questions about the standard of the doctor's practice. (A serious outcome may be avoided, for example, because of the intervention of a colleague).

The case examiners should follow the main decision-making guidance to assess whether the incident raises concerns about the doctor's practice which are serious enough to require referral to a medical practitioners tribunal.