



Independent review of gross negligence manslaughter and culpable homicide

Report of the Task and Finish Group on context of
the healthcare system in Scotland and Scottish law
relating to culpable homicide

June 2019

Working together for a just culture

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Background

- 1** The task and finish group (TFG) has been tasked with advising the Review on the key questions as they relate to the healthcare system in Scotland and Scottish law relating to culpable homicide (CH). The key questions the group has considered are:
 - With regard to the questions in the Review Call for Written Evidence, how do these issues apply in the context of Scottish healthcare settings and the application of the law in Scotland?
 - To what extent is there a consistency of approach across these issues in Scotland and, if there is consistency, how is this achieved?
 - How does the approach taken in Scotland address the issue of individual v corporate responsibility where there has been a fatal incident in a healthcare setting?
 - What are the benefits and drawbacks of the approach taken in Scotland?
 - What other issues should the GNM/CH Working Group take into account in relation to the investigation and potential prosecution of doctors involved in fatal incidents in healthcare settings in Scotland?

- 2** In gathering this evidence the TFG has met on four occasions. Members have provided advice on the basis of their experience and expertise of the issues under review in a Scottish context. This paper summarises the discussions of the TFG at their meetings in relation to their agreement or otherwise with the hypotheses posed. Reasons are provided for the findings as per the group's discussion. The paper also summarises the discussions of the TFG more generally in relation to issues being considered by the Review (up until early December 2018), and significant perceptions arising from the evidence the Review had heard up until that point.

Summary of the views of the Task and Finish Group

Processes leading up to a criminal investigation

Hypothesis: *There is not a consistent approach (with regards to methods and definitions) of why the death of a patient is investigated or not investigated.*

Hypothesis: *The quality of investigations is not consistent across the four countries. These inconsistencies include;*

- a) The level of training and/or resourcing of those undertaking investigations*
- b) The timeliness of investigations*
- c) The ability to access documentation and information sharing (such as electronic systems)*

- 1** The group agrees with these hypotheses. Their experience suggests that there is inconsistency at Health Board level with regard to both what is investigated, and the quality of local investigations. It was highlighted in a TFG meeting that the Sharing Intelligence for Health & Care Group in Scotland (jointly chaired by NES and HIS) has raised this as an issue.
- 4** Healthcare Improvement Scotland (HIS) has produced a national framework for 'Learning from adverse events through reporting and review'. This was published in July 2018. The framework includes both a definition of an 'adverse event' and guidance on how to categorise adverse events in order to determine the appropriate type of investigations required. Whilst this is a welcome step, there is no evidence to date that the variability in the quality of investigations has reduced.
- 5** The group suggests reasons for the inconsistent undertaking and quality of investigations into the death of a patient could include a lack of training and support for those conducting the investigations, and in particular the amount of experience of undertaking the investigations once trained. Other suggested factors relate to the culture of the organisation and its prioritisation of resource for investigations, particularly: the willingness of the organisation to invest in and resource training and to provide protected time to undertake investigations; and the organisational support for the duty of candour and freedom to speak up. These reasons are supported through the written submissions to the review as well as comments at the Scotland event (and others across the UK).

- 6 The TFG is aware that HIS intends introducing Quality of Care organisational reviews, the methodology of which is currently being tested before being rolled out nationally. This approach incorporates organisational/thematic reviews which include consideration of an organisation's approach to investigating and learning from adverse events. While the group is encouraged by this development, it suggests there is a need for some evaluation of these visits to determine their impact and efficacy.

Clarity of when doctors should refer to the Procurators Fiscal (PF)

- 7 The group does not agree that there is a concern with doctors in Scotland being clear on when to refer a death to the PF. The TFG feels that there is a generally consistent approach in Scotland, and that doctors know what matters to escalate to the PF and how to do this. They highlight the helpful guidance for doctors on referral to the Crown Office and Procurator Fiscal Service (COPFS), and that doctors can access advice through contacting the COPFS, and through the online system for reporting deaths. The group feel that doctors err on the side of caution in reporting deaths to COPFS, and there is also a consensus that doctors have the option to call and we heard that some do call the Death Certification Review Service for advice on completion of a Medical Certificate of Cause of Death and whether or not a case should be reported to the PF. This is supported by comments from attendees at the Scotland event. There was a general consensus from attendees there that they would be happy to call the PF directly, and that the PF service was helpful in providing advice.
- 8 The Death Certification Review Service, run by HIS, checks on the accuracy of a sample of Medical Certificates of Cause of Death (MCCDs). This process provides some assurance of the consistency and accuracy of the reporting of deaths, as it is responsible for delivering a national system of independent scrutiny of those deaths in Scotland not reported to the Procurator Fiscal including deaths occurring in the community. The TFG acknowledges that this process provides assurance via a sample, rather than a check of all hospital deaths (as is intended in the English system, where Medical Examiners will be required to certify and register all hospital deaths not requiring coroner's post-mortem or inquest). However the Scottish system is seen to be a proportionate solution and it has been implemented earlier than the English system (it was implemented in 2015).

The experience of patients and their families

Hypothesis: *Families and/or the patient's advocate are not always appropriately involved in the investigation and are sometimes undervalued as providing important insight into the events running up to the fatality.*

- 9 The TFG agrees with this hypothesis. The group feels that HIS guidance is clear, but that this is not yet followed consistently well. Evidence to the Review, including from the Scotland event, suggests that the process can be perceived as adversarial, and that someone resourced to liaise with patients/families, and trained to do this, would help. The provision of support and advice, independent from the Board, should be helpful and is recommended by HIS.

Family involvement in COPFS processes

- 10 The group believes the system for the COPFS engaging with families is robust. Deaths where medical negligence may be a factor are reported to the PF, and the PF engages directly with the nearest relatives, giving the relatives an opportunity to raise any concerns regarding potentially criminal actions with the PF. The PF can consider these concerns as part of the deaths investigation. It is felt that as a result of this, relatives rarely report directly to the police.
- 11 The Scottish Fatalities Investigation Unit (SFIU) of the COPFS has published a 'Family Liaison Charter'^{*} which may contribute to the consistent involvement of families. The family's involvement in the PF investigation may help them to get the answers they are seeking, both through the PF investigation, and because the PF can act as a conduit of information to the family. The PF can also instruct independent expert reports which are shared with the family.
- 12 The family cannot demand that a Fatal Accident Inquiry (FAI) takes place, but can express a desire to have one. The PF recommendation as to whether or not an FAI is required will take account of the family's views, but is not driven by them. Where a family wants an FAI, the PF reports to Crown Counsel. Crown Counsel (also known as Advocate Deputes) considers the PF report on behalf of the Lord Advocate, including the family's views and the wider public interest, in arriving at their decision about holding an FAI.

Role of mediation

- 13 The TFG is supportive and encouraging of the role mediation can play in situations where an adverse event has occurred and a family are unhappy with the answers provided. The benefits of the use of mediation for dealing with disputes in civil negligence claims have

* <http://www.copfs.gov.uk/images/Documents/Deaths/COPFS%20Family%20Liaison%20Charter%20September%202016.pdf>

been discussed by the group, and include: mediation being confidential, which means information exchanged cannot be used in further court-proceedings, so all parties can fully demonstrate duty of candour; claims go on pause for mediation; mediation does not have to be limited to cases where there is a dispute or court case; mediators are totally independent. It is suggested that mediation can help families receive apologies and/or an explanation.

Inquiries by a Coroner or Procurator Fiscal

Hypothesis: *The local based structure of the coroner service leads to inconsistency.*

- 14** The TFG feel this hypothesis is not applicable to Scotland. Suggested factors which support a more consistent approach in Scotland include: the PF dual role in investigating the circumstances of sudden, suspicious, accidental and unexplained deaths and public prosecutor; the existence of the Scottish Fatalities Investigation Unit (SFIU) of the COPFS, and its guidance for investigating deaths; and the requirement for an Advocate Depute, on behalf of the Lord Advocate, to authorise any prosecution for CH. Other reasons for the consistency identified in Scotland are suggested to include: cultural differences, including a perception of greater consideration of systemic factors in Scotland; and the public interest test in Scotland.

Hypothesis: *Specific guidance and support for investigating CH in a medical context should be developed.*

- 15** The TFG rejects this hypothesis. The group recognises that the SFIU is a specialist unit within the COPFS responsible for investigating all sudden, suspicious, accidental and unexplained deaths. The TFG highlights the SFIU's use of policy documents to inform its recommendations, including the SFIU Deaths Manual of Practice which provides internal guidance to COPFS staff making recommendations to Crown Counsel. Crown Counsel can discuss any case with the Lord Advocate before reaching a decision.

Hypothesis: *There are delays in the Procurators Fiscal process.*

- 16** The TFG is not in a position to confirm or dispute this due to a lack of data. While the group acknowledges that the COPFS is, at times, criticised for the length of time taken to make decisions, it is noted that this criticism does not relate specifically to medical cases. Given the extreme rarity of charges of culpable homicide being brought in Scotland in relation to medical practice, there is no meaningful data available on which to base an opinion. It is noted more generally, however, that even if delays in the PF process are not excessive, the process will inevitably impose stress on those involved.

Hypothesis: *More can be done to ensure that learning from coroner inquests and FAIs is shared to improve patient safety.*

- 17** The TFG agrees with this hypothesis. While there is an expectation that FAI recommendations will be followed, there is no formal mechanism for enforcing this. Consequently, there is nothing to ensure the same issues will not recur.

Lack of a body with oversight and ability to enforce appropriate improvements

- 18** The TFG is concerned about the lack of a body with a remit to oversee implementation of recommendations arising from FAI's. Similarly, there is no organisation with a responsibility to disseminate learning from FAI's to Boards across Scotland in order to help prevent the reoccurrence of issues. As a result, the group suggests that there should be a Scotland-wide approach to consider all learning from FAIs, and to aid and promote a prioritised implementation of learning nationally. While the COPFS can and does highlight learning from incidents it investigates with the relevant Boards, it is not responsible and does not have powers to pursue a Board if changes in response to 'lessons learned' are not implemented. The TFG suggests that the Review considers making a recommendation that a national approach is taken to learning from FAIs, and that a system is put in place in Scotland to ensure that the loop is closed on actions expected to be taken by the healthcare organisations involved. A similar approach should also be considered in relation to the findings of serious adverse event reviews (SAERs) undertaken by Boards.
- 19** The TFG suggest that the Review should highlight that the Williams Review recommendations for measures to improve the effectiveness of local investigations are directed to specific organisations (CQC and NHSI) which do not cover Scotland. In Scotland, there is no regulator of health boards. With one exception in relation to healthcare associated infection, only Scottish Ministers and the Scottish courts have the power to enforce a particular action on a health board. Specifically, it should be noted that Healthcare Improvement Scotland (HIS), the Scottish organisation comparable to the CQC and NHSI, does not currently have this power in its remit.

Police investigations and decisions to prosecute

Hypothesis: *The way the law in Scotland surrounding culpable homicide is currently framed makes criminalising medical errors unlikely. However, there are a number of other appropriate processes, aside from the criminal law, for addressing such errors.*

- 20** Following discussion at the TFG meeting, the above hypothesis was reworded to make it clear that CH is not the only route for addressing medical errors (for example other ways of addressing this might be through Fatal Accident Inquiries, Public Inquiries, Civil claims seeking compensation, the regulatory process, and through Health and Safety legislation). Worded in this way the TFG supports the hypothesis.
- 21** The reason for the lack of prosecutions for CH is suggested, in part, to be due to the way the criminal law in Scotland is framed, as recklessness, is required. Decisions on taking prosecutions are also taken with regard to the wider public interest. The law in Scotland around CH is based on common law and not on a statutory framework. It is acknowledged that future case-law or legislation could alter how things are dealt with in Scotland. The TFG is keen to emphasise that the position on the law surrounding CH does not mean there is any lack of accountability for medical errors in Scotland.
- 22** The group believes that it is undesirable to pursue criminal prosecutions in cases where a doctor has made one or more errors of judgement or omission without the intention to cause harm or by the application of wicked recklessness.

Corporate homicide

- 23** There is a high bar for prosecution of corporate homicide in Scotland, as per section 1(3) of the Corporate Homicide Act 2007,^{*} which states that ‘an organisation is guilty of an offence under this section only if the way in which its activities are managed or organised by its senior management is a substantial element in the breach [of the duty of care]’. As an example, the Vale of Leven Inquiry[†] was referenced, in which systemic errors were identified but not prosecuted. The TFG recognises that the criminal law is a relatively blunt instrument, and that public inquiries can provide greater opportunity to focus on learning and improvement.

* <https://www.legislation.gov.uk/ukpga/2007/19/section/1>

† <https://www.gov.scot/Topics/Health/Services/Preventing-Healthcare-Infections/Valelevenhospitalinquiry>

Hypothesis: *Specific guidance and support for investigating GNM/CH in a medical context should be developed.*

- 24** While there is no central team in Police Scotland for investigating CH in Scotland, the police are subject to the direction of COPFS in the investigation of crime and deaths and COPFS may direct that a death be investigated as potentially criminal. Therefore, there is an existing centralised process, and the TFG does not feel there is a need for a centralised unit within the police service in Scotland, nor is there a need for any additional guidance to be issued.
- 25** Consistency with regard to the investigation of CH cases is brought about by the existence of a centralised investigation unit within COPFS, the Scottish Fatalities Investigation Unit (SFIU) and a National Homicide Team. Two other reasons for consistency in Scotland are due to: investigations being directed and decisions being taken independently and impartially by Crown Counsel and decisions being subject to national guidelines and instructions from the Lord Advocate.

Perception exists that prosecuting authorities ‘prosecute to win’

- 26** The TFG notes that the prosecutor’s duty in Scotland is not to “prosecute to win”, but to prosecute ‘in the public interest’. The role of the prosecutor in Scotland is to present all relevant facts in the context of an accused person’s right to a fair trial. It is acknowledged that, in the exercise of its prosecutorial functions, COPFS takes into account all of the circumstances of a case including the public interest.

Hypothesis: *Prosecutorial authorities should ensure that their procedures are transparent and made known to the public in order to support wider confidence in the robustness of their decision making processes. This includes appropriate quality assurance or peer review processes and unconscious bias elimination.*

- 27** The TFG does not consider that there is a lack of transparency in COPFS processes. COPFS produce information about the process of death investigation and prosecutorial decision making in Scotland. The COPFS guide to the FAI process is publicly available.
- 28** A lack of data on the number of cases investigated for CH and GNM has been identified as an issue by the Review. The COPFS has clarified that it uses a live operational case management system, specifically designed to receive criminal and death reports from the police and other specialist reporting agencies and to manage the cases for investigation and prosecution purposes. The information held on the system is structured and coded to meet these operational needs, rather than for statistical reporting or research purposes. Therefore, the COPFS does not record:

- Deaths data with reference to the occupation of the persons potentially responsible for the death, meaning that they would be unable to provide statistics on the proportion of CH prosecutions relating to medical professionals compared to any other profession or industry.
 - Information about the proportion of cases in which the PF instructs the Police to investigate a death.
 - Conviction rates for any category of offence. In Scotland, the Scottish Courts and Tribunal Service are responsible for recording case outcomes. The Scottish Government uses this data to publish annual conviction rate statistics across a variety of offences, but this does not include data on CH (possibly due to the small number, or lack of, cases).
- 29 Whilst the availability of robust data on CH prosecutions involving doctors would help inform them about the risk of prosecution, the TFG considers that in the Scottish context collecting this data will not address or help to resolve the issues that doctors are actually concerned about - such as the availability of appropriate support and supervision and the challenges and pressures of the working environment. It should be noted that the data which is available indicates that there have been no doctors successfully prosecuted for CH in cases of alleged medical negligence.
- 30 The Review has noted the good practice highlighted in the report of the ‘Lammy Review: An independent review into the treatment of, and outcomes for Black, Asian and Minority Ethnic individuals in the criminal justice system’,^{*} in relation to positive examples of CPS QA and peer review processes. The TFG note while there is no formal QA process in COPFS, the small scale, the centralisation of processes and the existence of clear policies mean that the quality and consistency of case handling is, to an extent, built in. Furthermore, the TFG has been advised that any case potentially involving the prosecution of a doctor for culpable homicide would be considered by Crown Counsel on behalf of the Lord Advocate. It is also noted that where a decision is taken not to proceed with a case, the COPFS will explain to the family why the case is not being taken forward.

* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/643001/lammy-review-final-report.pdf

The use of medical experts and the criminal proceedings

Hypothesis: *There should be a greater standardisation in the way expert witnesses are selected with regards to their (skills, knowledge and training) and how they should be quality assured. There should be standardised terms of reference for instructing expert witnesses.*

31 The TFG agrees with this hypothesis. The group believes there is a need for processes to provide assurance on: how recent an expert's experience in the relevant field is; that the qualifications the expert has are relevant to the case being considered; and that the views of the expert fall within an acceptable range of medical opinion. The group is keen to stress they are as concerned as the rest of the UK that this is an area which requires focus and action.

Perceived lack of disclosure

32 The TFG has also discussed the perception that prosecutors can select opinion to support their case. The rules around disclosure in Scotland in criminal cases mean that the Crown has to give full disclosure of any material evidence, including all expert opinion commissioned. Therefore, the prosecuting authorities cannot conceal contradictory expert opinion received and would be obliged to provide that opinion to the defence.

Culpability

33 We would expect that more than one opinion would be sought on the issue of culpability for a CH prosecution of a doctor. It is also open to the defence to instruct their own independent expert report and to lead that expert before the jury at any subsequent trial.

Need for/benefit of instructing more than one expert.

34 It has been pointed out to the TFG that in Scotland experts are often brought together if they hold different views, in order to form an agreement where they can, and to highlight their ongoing areas of disagreement.

35 The TFG recognises that COPFS instructs a number of experts in its criminal and deaths investigation work. COPFS commissions its own expert opinion, but having access to the GMC's pool of experts would provide it with another source of opinion. This would simply be a way of assisting COPFS in finding appropriate specialist advice. The GMC at present has no role in accrediting experts.

The professional regulatory process

Hypothesis: *There would be advantages in the GMC considering cases of potential GNM/CH through its normal regulatory processes in advance of any decision on criminal action by the prosecuting authorities.*

- 36** The TFG rejects this hypothesis.
- 37** It is acknowledged that the Lord Advocate would not relinquish control over whether or not an individual is prosecuted. However, this does not mean that regulators should defer taking action where it is necessary in the interests of protecting the public.

Employment and support

Hypothesis: *Staff involved in the incident do not receive adequate levels of support throughout the investigation process and/or after the initial event has happened.*

- 38** The TFG feels that similar issues exist in Scotland to those identified in England. The TFG recognises that employers and Designated Bodies have a duty of care to their employees in such cases, and also flags a potential lack of support for doctors involved in undertaking investigations.
- 39** The TFG acknowledges that there can be gaps in mental health support for doctors involved in incidents, similar to those identified in England. The TFG feels this should be addressed by the Review group's recommendations. The TFG also recognises the importance of medical defence organisations in supporting doctors involved in investigations and is concerned that some doctors may not be aware of the risk of solely relying on crown indemnity provided by NHS organisations. The group would like this issue to be highlighted by the Review.
- 40** The GMC commissions the BMA to provide independent support to doctors who are being investigated by the regulator. The TFG would like Review Group to consider recommending that the GMC expands this cover to doctors involved in local investigation processes.

Hypothesis: *Medical professionals are not adequately trained before appearances at coroners' inquests and are not adequately supported before and during the inquest.*

- 41** The TFG agrees with this hypothesis, insofar as it can be said to apply in Scotland, but feels the word 'trained' is incorrect in terms of doctors involved in the PF process and should be replaced by 'prepared' or 'supported'. This preparation and support could equally come from a medical mentor or a legally qualified person. There may be benefit in having both in place. The group recognises that a number of sources of support are already available, for example: HR colleagues within a health board or other employer; medical defence organisations and medical royal colleges. COPFS guidance on FAI processes is also publicly available. The issue of who should get this support, and when, has been considered by the TFG. It feels that this should be targeted at those who need it, when they need it rather than an attempt being made to make all doctors aware ahead of time.



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