

# Terms of reference: Review of gross negligence manslaughter and culpable homicide

## Purpose

- 1** To consider gross negligence manslaughter and culpable homicide (in Scotland)<sup>1</sup> in relation to the perceived vulnerability of the medical profession to charges of GNM/CH. Further, to examine what might be done to improve the application of the existing law, procedures and processes to address this in the light of two recent high profile cases involving doctors, whilst maintaining the core objective of protecting the public and maintaining confidence in the profession.
- 2** To consider how the GMC should handle such cases in future. This review will not be considering particular doctors' cases, although it will consider wider questions and issues raised by them. It will also cover equality, diversity and inclusion issues, including whether there is fair and consistent representation of particular groups of doctors with protected characteristics in allegations of GNM/CH.
- 3** This work will be informed by the outcome of the rapid review into the application of GNM in healthcare in England and Wales, announced by the Secretary of State for Health and Social Care on 6 February 2018 and due to report in Spring 2018.
- 4** This review aims to encourage a renewed focus on a fair and just culture, reflective practice, individual and systemic learning (with a view to enhancing patient safety) and the provision of support for doctors in acting on concerns.

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<sup>1</sup> Different legal provisions exist for gross negligence manslaughter and, in Scotland, culpable homicide. However, for the purposes of simplification in these terms of reference, 'gross negligence manslaughter' and 'culpable homicide' are generally referred to collectively as GNM/CH. The review will wish to understand the differences between the two systems and how they operate in practice.

## Objective

- 5 To produce recommendations that will support just decision making and application of the law, procedures and processes where allegations of GNM/CH have arisen so that accountability is appropriately apportioned between healthcare systems and individual doctors.

## Scope of review

- 6 The review will assess the available evidence on the operation and impact of the whole process that could lead to a doctor's conviction of GNM/CH and the relationship between the criminal processes for GNM/CH and the professional regulatory process. The review will cover GNM and culpable homicide (in Scotland) in healthcare and their application in all four countries of the UK. This review will not consider any changes to the law of GNM/CH or the autonomy of the decision making of the prosecuting authorities or the courts.
- 7 The review will consider all stages of the process that might follow a medical decision leading to a fatal incident and an allegation of GNM/CA. These include local investigation procedures within an employing/contracting organisation, the involvement of the coroner, the police, or sheriff in Scotland, Crown Prosecution Service (CPS) in England and Wales or the Crown Office and Procurator Fiscal Service (COPFS) in Scotland, as well as the subsequent criminal trial and professional regulatory proceedings.
- 8 The issues to be explored include:

### *Post incident, pre-criminal investigation*

- The quality of local investigations (e.g. an NHS Trust).
- The distinction between errors and 'truly exceptionally bad'<sup>2</sup> failings which amount to GNM.
- The lack of corporate manslaughter prosecutions against healthcare organisations as compared to individual healthcare professionals within organisations facing GNM prosecution, any differences in approach between the UK countries and the possible reasons for this.

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<sup>2</sup> *R v Misra* [2004] EWCA Crim 2375

### *Inquiries by Coroner, Procurator Fiscal or Sheriff*

- What can be learned from past decisions to refer or re-refer matters (arising from a medical setting) to the police and the adequacy of guidance available to coroners, procurators fiscal and sheriffs.
- Whether there are avoidable delays in the process.
- The role of medical expert evidence and its appropriateness in relation to the practitioners being investigated.

### *Police investigations and decisions to prosecute*

- Whether the key decision makers (the police senior investigating officers (SIOs), and/or CPS or COPFS) have the necessary support to enable them to make fully informed decisions on whether or not to charge a doctor of GNM/CH.
- Data on the number and nature of criminal investigations and subsequent criminal and regulatory processes against medical practitioners relating to GNM/CH. This will include looking at the relationship between the number of investigations of medical practitioners compared to the number that result in a conviction for GNM/CH and what conclusions might be drawn from this.
- Whether there are factors which potentially hamper key decision makers in making fully informed and consistent decisions, taking into account all the circumstances that the medical practitioner found themselves in at the time of the fatality, such as system pressures and other factors.
- The proportionality and appropriateness of cases being referred to the criminal justice system and whether some cases could be more appropriately considered within the regulatory fitness to practice process instead of the criminal process.

### *The use of medical experts and the criminal proceedings*

- The selection and use of the medical experts within the criminal justice system in cases of alleged GNM/CH.

### *The professional regulatory process*

- How the regulatory system works when cases are referred into its processes.
- The meaning, appropriateness and measurement of 'public confidence' as an objective of the regulatory process. This will include understanding patient

and public expectations of regulatory processes after a practitioner has been convicted of a criminal offence.

- Whether there could be more clarity in GMC guidance and communication around the role of reflective practice.
- The extent of emotional, pastoral and other support available for medical practitioners who are the subject of an allegation or charge of GNM/CH.

### *Employment and support*

- How to support and encourage a learning culture and improve medical practitioners' confidence in the effect of signalling near misses and errors or raising a patient safety concern without fear of unwarranted reproach/blame.
  - The adequacy of guidance and support available to medical professionals and employers where a doctor is subject of a GNM/CH investigation. This includes guidance about a practitioner's ability to continue working whilst criminal and regulatory proceedings are ongoing, as well as provision of supervision, refresher training, remediation and continuing professional development where there has been a lengthy break in or suspension of practice.
- 9 The review will not include an assessment of the adequacy and appropriateness of the law itself, but will consider its practical application.

## **Working arrangements**

### *Approach*

- 10 The review will be undertaken by a working group, the composition of which is currently being finalised. The review group will determine its own working methods. However, there is an expectation that the review process will include the following elements:
- Initial consideration of the issues by the working group.
  - The work of the group will be informed by research and consultation involving a call for written submissions from key interests and symposia. It may also be necessary to follow this with further direct conversations and taking of oral evidence.

- The working group will use the learning from these activities to further develop and refine recommendations for a final report to be presented initially to the GMC and then published.
- 11** Since it will not be practical for the working group to include all key interests, it will be essential for the group to develop working methods which enable effective engagement with those interests across the four countries of the UK.

### Timescales

- 12** The working group will aim to report its findings to the GMC by the start of 2019.

### Contact details for GNM review

- 13** Please direct any queries in relation to these terms of reference, or the review, to the following email address: [ReviewofGNMandCH@gmc-uk.org](mailto:ReviewofGNMandCH@gmc-uk.org).

### Version control

Version one	Published 16 March 2018
Version two	Published 8 June 2018. Terminology used in relation to <i>'Police investigations and decisions to prosecute'</i> was updated, following feedback from the Crown Prosecution Service.
Version three	Published 31 July 2018. Email address was amended, following a change in leadership of the review. Dame Clare Marx stepped down as chair on 30 July 2018 and was replaced by Leslie Hamilton.