Report: responses to the call for written evidence submissions to inform the independent review of gross negligence manslaughter and culpable homicide

About the call for written evidence submissions

1. The GMC commissioned an independent review of the issues surrounding gross negligence manslaughter (GNM) and culpable homicide (CH) in Scottish law\(^1\) involving doctors. The review is led by Leslie Hamilton and supported by a working group comprising doctors, a doctor in training, lawyers, and lay representatives. This review follows recent high profile cases\(^2\). It is currently in the evidence gathering stage - with the call for written evidence submissions being a key part of that. The review is seeking to understand how the law and regulatory processes operate in this area and to identify opportunities for improvement in procedures and processes which will support just decision making and the application of the law.

2. Given the breadth of issues covered by this review, we welcomed views in writing from a wide range of individuals and organisations, including: the medical profession, patients and family members, the legal profession, police and prosecuting authorities, medical defence and other representative organisations, employers, educators, academics in the field, other regulators and any other individual or organisation with experience of, or expertise in, gross negligence manslaughter or culpable homicide.

Brief high level overview

3. Thematic analysis of the responses we received to the questions will be laid out as per the below. These were the headings for the grouping of questions in the call for evidence so that respondents could choose which sections they felt they could or wanted to answer:

- What people perceive to be ‘criminal acts’ by doctors

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\(^1\) In Scotland there is no offence of gross negligence manslaughter. The offence is involuntary culpable homicide. There has been no successful prosecution of a doctor involving this offence (which may not alleviate healthcare professionals’ fears of prosecution). Involuntary culpable homicide in the course of lawful conduct may be committed where death is caused by an act or conduct in the face of obvious risk which were or should have been appreciated and guarded against showing a complete and reckless disregard of potential dangers and consequences which might result.

\(^2\) Information about the appeal case of Dr Bawa-Garba can be found on the GMC’s website [here](https://www.gmc-uk.org/) and David Sellu, a colorectal surgeon who served half his 30 month sentence in jail and half on licence- and conviction quashed on appeal.
- The experience of patients and their families
- Processes leading up to a criminal investigation
- Inquiries by a coroner or procurator fiscal
- Police investigations and decisions to prosecute
- The professional regulatory process

**Methodology**

4 The call for written submission evidence ran from 04 June 2018 to 10 August 2018.

5 We published a list of 52 substantive questions online on the review’s webpage (a full list of the questions can be found at *Annex A* to this report). All of these questions were free text responses with the final question offering the opportunity to add any additional comments respondents may have had.

6 Most respondents completed the questionnaire on SmartSurvey, an online survey tool/software. However, some sent us submissions or comments in other formats via email to the review’s inbox ([ReviewofGNMandCH@gmc-uk.org](mailto:ReviewofGNMandCH@gmc-uk.org)).

7 In addition to this call for written evidence submissions, the review ran a number of engagement events across the UK in the Autumn 2018. The events are to engage and to seek feedback/views from our key interest groups on the issues and themes connected with gross negligence manslaughter and culpable homicide in a medical setting. Attendees included: patient families, doctors, doctors in training, representative organisations, lawyers, voluntary organisations/charities, coroners, regulators and other stakeholders.

8 We will supplemented the evidence gathered in the call for written evidence submissions with a number of oral evidence sessions across the four countries of the UK in Autumn 2018. The oral evidence sessions were an opportunity to explore key issues raised in submissions further.

9 During the period in which the call for written evidence submissions was live (4 June and 10 August) we also gathered experiences and views from responsible officers via the General Medical Council’s [employer liaison advisors](mailto:ReviewofGNMandCH@gmc-uk.org) who meet with responsible officers regularly. Responsible officers (ROs) were asked three questions which focused on the support available to doctors, the role of local investigations and the GMC’s role in maintaining public confidence and professional standards. Analysis of the feedback received from ROs can be found at *Annex B* to this report.
About the respondents

High-level summary of respondent categories

10 There were 729 individual responses in total to the call for written evidence.

11 684 responses were completed and submitted on the online survey, with a further 45 responses submitted to the review’s email inbox.

12 These responses (online and offline) are the basis for the quantitative analysis and the various tables that can be found at Annex C. All the responses have been subject to qualitative analysis that we’ve reported below and have been considered as evidence to the Chair and working group members.

13 In response to the following question: ‘Please select the group below that you feel applies most to you or the organisation you are responding on behalf of,’ there were 721 respondents who selected ‘the medical profession’, 37 are from ‘professional representative/organisation or trade bodies’, 15 are from the ‘legal profession’ or ‘academics’ and 29 are from ‘patients, family members’ or ‘patient representative organisations.’

14 In this report we have generally avoided naming individuals, however we have named a few individuals who have responded on behalf of an organisation (in a professional capacity) and/or some of those who have indicated that they do not mind being named, particularly where they are key individuals in this area, with subject matter expertise and interest.

3 Or were identified as a medical professional in an offline submission to the review inbox.
Key overall findings

15 It is important to stress that this report provides a descriptive account of what the individuals and organisations who responded to the call for written evidence have told us. It is not an evaluation of that evidence. Any conclusions to be drawn from this evidence, from the other material collected and the research undertaken during the course of the Review will be set out in Review’s final report.

16 Clearly the nature of the topic in question here, namely following avoidable deaths of patients is extremely emotive, and potentially distressing and traumatic. Therefore, we recognise that strong perceptions and feelings about the effectiveness of systems, processes and organisations following patient death are perhaps to be expected. However, overall the responses paint a damning picture of perceptions about what happens following patient death based on the respondents’ experiences.

17 The responses indicate overwhelming levels of distrust, (from all respondent groups) in the law, processes, organisations and systems involved. Frustration, fear, disappointment and in some cases, anger is apparent. Whilst this was the majority verdict, there were some who shared elements of positive experience and there is some evidence of pockets of effective processes/mechanisms which can be learned from.

18 Key themes in the written responses, included:

19 The utmost importance of a ‘good quality’ local investigation in the first instance and the crucial input of relevant independent medical expertise throughout all the processes following patient death.

20 Almost universal support for the improvement of processes for communication with, and support for, bereaved families. This should be as early on as possible following a patient’s death. Involvement and support of patients and family members in investigations is viewed as paramount to an effective investigation.

21 Many respondents highlight the issue that doctors suffer multiple jeopardy ‘when a mistake is made’ and face investigation/judgement by their employer, the coroner, the civil and criminal courts, their regulator, and/or a systems regulator. Many also highlighted the length of time these investigations take and the detrimental impact they have on doctors’ health, lives and careers.

22 In regards to local investigations by healthcare organisations following patient fatality- we were told that they are variable in quality, do not adequately support or communicate with staff or families, are inconsistent, focus on blaming individuals and lack independent review and medical expertise. There was also
recognition of deficiencies in how root cause analyses are carried out and a lot of support for a human factors approach/assessment in investigations going forward.

23 In regards to police investigations and decisions to prosecute doctors – overall we were told that there are significant perceived issues with regards to a lack of: expertise of specialist/technical medical issues, timeliness (typical for doctors to be on bail for two years from the time of their first police interview, to a charging decision being made), and consistency across the country (eg 43 police forces across England and Wales).

24 In regards to medical expert evidence (for local investigations, police, prosecutors, coronial services and the professional regulator) – we were told that there are significant issues with ensuring ‘independence’, ensuring lack of bias, current and relevant ‘expertise’ (who really is an ‘expert’?), quality of reports/opinions (including them being unrealistic in the context the doctor found themselves in), and a lack of knowledge of any methods of ‘quality assurance’ other than doctor appraisal.

25 In regards to the GMC’s fitness to practise processes and MPTS- we were told that doctors feel like they are treated as though they are guilty until proven innocent. Investigations are too lengthy and cause significant stress and worry for a doctor. Some said they thought the processes were not fair, were unnecessary or disproportionate (including that they covered all the ground already covered by the criminal process) and lack transparency.

26 There is evidence of some support available for doctors, however it is reportedly inadequate and inconsistent across organisations, areas of practices and across the four countries of the UK. There are limitations to the support available, primarily around accessibility and varied levels of understanding amongst the medical professionals. More can be done to improve the support offered to doctors, particularly to ensure greater consistency across specialties and nations, and to ensure that there is better awareness/accessibility of the support that is available.

27 There was also considerable support for encouraging a just, patient safety and/or learning culture, (particularly in the NHS as this is what is in most people’s experience of healthcare), with much recognition of the drive towards this already. Many referred to a need for a ‘no blame’ culture, whereas others say it should be a ‘just’ and/or ‘fair’ culture.

28 There was extensive exploration in responses of the need to ensure that healthcare professionals are supported/enabled to report patient safety concerns without fear of unwarranted individual blame. Some highlight the balancing need to always ensure appropriate levels of accountability for unacceptable failures by individuals but still ensuring that non-individual issues are identified and addressed too, in order to improve patient safety. However, many raised the difficulties in achieving such a culture in the context of the issues explored in this review.
patient death in the pressured healthcare systems of the UK and the interplay with the adversarial criminal justice, litigation and regulatory systems.

29 There were also many responses which drew upon other cases where they felt (eg whistle blowing) doctors were treated unfairly by investigative/adjudicative bodies as evidence of how the wider profession are justified in their fear of unwarranted persecution when they try to raise concerns and improve patient safety, these included:

- Professor Edwin Jesudason, a paediatric surgeon from Alder Hey Children’s Hospital, (who was ‘forced out of his job after alleging that children had died and suffered harm due to poor surgery’).

- Dr Chris Day, a doctor in training who raised concerns about dangerous staffing levels who was then wrongly ‘performance managed out of his training post’ (his case resulted in a Court of Appeal ruling (overturning the Employment Tribunal judgment) in which Health Education England was eventually held responsible for providing statutory protection for whistleblowing doctors in training, which they employ).

- Dr Raj Mattu, a consultant cardiologist was dismissed by the Trust in 2010. In 2001 he had exposed the cases of two patients who had died in crowded bays at Walsgrave Hospital in Coventry. In April 2014 an Employment Tribunal found he had been subject to ‘many detriments’ by the trust as a consequence of being a Whistleblower.

30 Many say that individuals are scapegoated and non-clinicians/managers/healthcare providers/boards do not take any responsibility for their failings/errors and/or are not (visibly) held to account. They say this prevents learning and change for the benefit of patient safety. Many respondents highlighted the lack of any criminal action against non-medical managers/board members (i.e. corporate manslaughter). The problem was highlighted by Sir Ian Kennedy QC, speaking at the Royal College of Surgeons of Edinburgh’s triennial conference on 22 March 2018, who said ‘...medical manslaughter means that you can pick someone, blame them, and imagine that you’ve solved the problem. And what you have actually done is exacerbated it.’

31 Many drew on the extensive history/body of work (including numerous inquiries and reviews, eg Morecombe Bay, Gosport War Memorial Hospital and most frequently, Sir Robert Francis QC’s reports following Mid-Staffordshire) focussing on ways to improve and embed a fair, just and learning culture.

The role of medical manslaughter must be reconsidered, says leading lawyer
https://doi.org/10.1136/bmj.k1376 (Published 23 March 2018) BMJ 2018;360:k1376
32 One senior medical professional summarises in their response, the issues currently causing controversy in this area helpfully by explaining they:

‘...relate to the boundary between medical and legal cultures. There is a sense that the medical culture is moving along a path of valuing openness and tolerance of individual error as a vehicle for greater safety through improvements in individual and team functioning. By contrast the legal culture continues at present to maintain a culture of individual culpability as the guardian of safety. The medical culture must reasonably accept that there must at some point be individual accountability, and the legal culture that there is value in learning. The difficulty is that at present the tipping point between both is indistinct. It would be very helpful to reach a point where both cultures subscribe to a shared culture of balanced accountability whereby responsibility continues to be apportioned but there is a greater value placed on the potential for remediation and with it forgiveness of error, even those with major consequences.

The question should be less about what has happened before, and more about how we make things safer in the future. We must censure, remove licences and even convict some individuals, and we must remediate, supervise and support others. Both extremes of response are appropriate in some circumstances; our task is to work out which to use and when. Within this we must consider the impact on the collective of perceived unfairness on an individual and the risk that safety will be compromised by a nervous and defensive workforce just as it may from malpractising individuals.’

Complexities/challenges with application of the law of GNM in the medical context

33 A key theme arising out of responses was the unique factors of practice as medical professionals (or healthcare professions generally, although recognising that in multi-disciplinary teams it is mostly the doctor with ultimate responsibility for the patient) and the difficulty it presents in proper application of the law of GNM and how ‘it doesn’t work’ or ‘isn’t fair’, particularly in comparison with other professions. The detail on this is provided in the final section of analysis of individual questions, in which respondents were asked for any further comments they wished to make.

34 As can be seen in the section above (‘about the respondents’), the category of respondents with the most responses was, by far, the medical profession (comprising 88% of online responses).

35 Many of them drew on issues arising from, or focussed their comments on, the recent appeal case of Dr Bawa Garba. It is important to note, and to bear in mind when reading the analysis below, that the Court of Appeal’s decision to overturn the High Court decision to remove Dr Bawa-Garba from the medical register was
not known until after the deadline for this call for written submissions. These comments relating to this case mostly highlight their significant concern that:

- A law abiding citizen should not be made a criminal for human error in a profession where risk is inherent. No healthcare worker who is trying their best in often suboptimal conditions, (i.e. with systemic issues present - giving the examples of, ‘where there was a clear back-drop of inadequate patient monitoring, senior support, and IT failure’, or where there ‘are multiple professionals involved in the patients care leading up to the death, complex multiple co-morbidities, and/or complex pharmacology’) should ever feel that if they act in good faith they risk criminalisation or losing their livelihood. Some respondents highlighted David Sellu serving half of his 30 month prison sentence before his GNM conviction was overturned on appeal.

- A one off avoidable death in an otherwise unblemished career should not result in destroying a healthcare worker's career. They would never make that/those unintended mistake(s) again and would be safer clinicians as a result of lessons learned. Therefore, they did not see why Dr Bawa-Garba could not continue to practise with adequate insight/training/remediation.

- Fear of prosecution for GNM/CH makes doctors feel as though they practise defensively. Doctors will not own up to near misses and will lose vital learning opportunities. Further, many commented that they believe recruitment of doctors will become more difficult, or they will leave the profession/country, or avoid ‘high risk’ areas of practice, making workforce pressures even worse than they are.

- The risk of criminalisation of medical error/GNM, rests on the consequence/outcome of the error not the level of culpability or nature of the doctor’s conduct, which is viewed as unfair/unjust. They highlight that Dr Bawa-Garba ‘was (wrongly) punished for the outcome of her errors (Jack Adcock’s death) not her actions. Others have made the same or similar errors and more serious ones without prosecution…. It is not about competence here, it is about context.’

- Dr Bawa-Garba would not have been prosecuted or convicted under the Scott’s law of culpable homicide. That inconsistency in the criminal law in the UK is seen as inherently unfair. Respondents also highlight the differences in the criminal justice system and healthcare system in Scotland, and their approach following patient death, which could explain why there haven’t been culpable homicide convictions in the medical context.

- Many highlighted the protected characteristics of Dr Bawa-Garba and other doctors recently convicted of GNM (for example David Sellu). Respondents most frequently mentioned their belief that this was because they are black, minority and/or ethnic doctors, and their perception that they were blamed and prosecuted because of it, or at least that the decision to investigate and prosecute, and for the jury to convict, was influenced by unconscious bias or racism.
Many also point to the characteristics/profile of patients in potential cases of GNM in a medical setting and argue that they seemingly influence decisions to investigate doctors, potentially prosecute, and for juries to convict. For example, many claim that if a victim is white and young, they are more likely to face prosecution. In contrast they highlight the lack of prosecution of Dr Barton (or her supervisors) in relation to the death of elderly patients at Gosport War Memorial Hospital.

They also draw attention to the role of the media in this context and how doctors frequently feel as though there is ‘trial by media’ which is prominent in, but not limited to GNM cases - but anything a doctor could be said to have done ‘wrong’ by the tabloid press (with many evidencing their point with the case of Charlie Gard).

The GMC should not have appealed MPTS’ decision to suspend Dr Bawa Garba and should have respected/trusted their expert decision. The strength of opinion in the majority of responses from the medical profession in this regard cannot be overstated. They highlight that the decision has had a profoundly negative impact on the reputation of the GMC and the profession’s confidence in their regulator to deal with doctors’ cases fairly, robustly and transparently.

Many felt that the GMC has wrongly interpreted its role in promoting and maintaining public confidence in the medical profession. Saying the GMC have relied on tabloid press/media coverage or bereaved family’s opinion, as evidence of what will undermine public confidence (as opposed to an ‘intelligent and informed member of the public’). Further, many say the decision itself has actually undermined public confidence unnecessarily, as Dr Bawa-Garba was ‘a good doctor’. Many argued for the GMC having a role in educating the public on the pressures doctors face and the impact this has on their ability to perform. We are repeatedly reminded that doctors are humans and thus prone to making mistakes, which doctors believe the public do not generally expect.

Many highlight the perceived inadequacy of the GMC’s decision making process for an appeal (with the decision in statute being vested in an individual, the registrar of the GMC - the Chief Executive). There was also a frequently held perception that doctors are held to much higher standards than the GMC adheres to itself. Quite a number or respondents felt that the GMC should go back to having a greater number of medical professionals in its leadership/council.

Contrary to the above, there were also many respondents who felt that the GMC’s decision to appeal MPTS’s decision was correct or unavoidable, and that a conviction for a homicide offence, namely GNM is incompatible with continued registration as a doctor.

36 Responses from trade unions, representative organisations and colleges predominantly reflected the concerns raised in the themes highlighted in medical professionals’ responses outlined above and reiterated that the medical workforce
faces significant challenges and pressure. There are workforce shortages across the country with rota ‘gaps’/issues creating additional pressures in an already difficult environment, which they argue increases the likelihood of error/mistake. They say there is a pressing need to value healthcare professionals at every stage in their careers, to ensure that medicine remains an attractive career choice and offers support for medical professionals as they progress throughout their careers. Many respondents say there is a need to remind the public that doctors are human and prone to make mistakes.

Themes from patient or family member responses

37 The response rate from patients and family members was comparatively very low (comprising 4% of all online submissions, although to note, this is not unusual for questionnaires of this kind). The majority, if not all, of these respondents drew on their personal experience following bereavement. Again, that was to be expected from a questionnaire of this kind.

38 Overall, most of the responses from patients or family members were in contrast to most of the views shared by the medical profession (although noting the few who agreed with doctor’s views on the issues). These respondents told us:

- They have had personal experience of a family member dying as a result of a doctor(‘s’) error, which some felt should have resulted in a criminal investigation for GNM, CH or murder, but didn’t.

- Family members are not adequately involved in local investigations, they do not receive the explanations they need and they find that there is a lack of communication with them throughout the investigation process.

- Healthcare organisations (eg the trust) ‘cover’/’protect’ themselves and conceal the ‘truth.’ They also believe that healthcare professionals also protect themselves and each other. This perception extends to medical experts who instructed by the organisations involved.

- The police, the coroners, the Procurator Fiscal and/or the GMC (and in some cases, the NMC) do not investigate ‘properly’ or take family member’s concerns seriously.

39 Conversely there were a couple of family members who recount their positive experience, where the healthcare organisation and medical professionals were open, transparent, apologised for their error and focussed on learning lessons and making patient safety improvements. Similarly, whilst a couple of others didn’t have this experience, they argued that this was the right approach to take or the one they wish had been taken following the death of their family member. They saw little to no benefit in singling out individual healthcare professionals to blame.
and called for changes in the culture of the healthcare systems to one of patient safety and learning.

40 Overall there was also some recognition for the work of this review being a very important opportunity to improve the current situation and provide clarity around how these cases are handled.
Responses to individual questions in the questionnaire

What people perceive to be ‘criminal acts’ by doctors

Question 9. What factors turn a mistake resulting in a death into a criminal act?

There were 649 responses to this question online.

The most common factors which respondents thought turn a mistake resulting in patient death into a criminal act that we were told by all respondent groups were:

- Intent (mentioned 190 times in online submissions\(^5\))/intention (87 times)
- Deliberate (150 times) harm (300 times)/deliberately (56 times)/knowingly (61 times)
- Wilful (56 times) to do something wrong, or ‘malicious’. Examples given were doctors under the influence (65 times) of/using drugs (70 times) or alcohol (57 times) while treating a patient
- Reckless, or ‘acting outside area of competence when a safer option was available’, or an ‘overt omission that a reasonable professional would know would lead to death.’
- Dishonesty/‘covering up post mistake’

Most respondents focus appeared to be on the state of mind of the doctor (i.e. the \textit{mens rea} element of criminal offences) – arguing that there must be a deliberate wilfulness to be negligent as opposed to ‘just a mistake.’

Some medical professionals were concerned with the use of the term ‘mistake’ in this context, which implies ‘inherent honesty’ and that there was no intent. There was also concern that what shouldn’t turn mistakes resulting in a death into a criminal act, are issues surrounding system pressures, or protected characteristics of doctors.

There were very few medical professional participants who believed that no doctor should be classed as ‘a criminal’ regardless of the type of care they may have provided or that it should only ever be a civil matter, not criminal.

Interestingly, one participant argued that... ‘the elements of the crime...should include the element of bad faith...the core values of a fiduciary relationship [between doctor and patient] include the necessity to avoid a conflict of interest; a duty of undivided loyalty; and a duty of confidentiality. It is clear that dishonesty, fraudulent behaviour and any other activity on the part of the doctor that is inconsistent with the trust that the patient invests in the doctor is contrary to this relationship. The surgeon who brands a liver whereby as a result the patient dies would be an example. In the more usual currency of good and bad faith, it can be seen that the fiduciary relationship protects patients from doctors acting in bad faith. It is only a small step to conclude that the threshold for circumstances where doctors whose actions bring about the unlawful killing should reasonably be charged with

\(^5\) Amount of mentioned words in online submissions will be referred to after this item just as the amount ie ‘xx times.’
gross negligence are those where the doctor was acting in bad faith. And that doctors acting in good faith should not be charged, notwithstanding the patient’s resultant death.’

Another respondent noted that…’ if a doctor were to neglect their duty by, for example, not reviewing a patient because the doctor was doing something for their own benefit, e.g. had left the hospital or practice to play golf or any other personal activity, then, yes, if a death resulted as a consequence of them not being there when they should have been, that would verge on the criminal, in my opinion. However, the question refers to a mistake- can human error ever be criminal? I’m not sure.’

The Patient Association told us that:

i. The principles of what constitutes a criminal act are well established. They require not only that an unlawful act is committed, but that it was in some meaningful way intended. This intent can be direct or indirect, including being aware of the certain or virtually certain consequences of one’s actions without actively desiring them, being in a position where one should know the certain or near-certain consequences of one’s actions but failing to foresee them, or knowing the consequences but not caring.

ii. The question might therefore be framed as how these principles translate into a healthcare setting. Patients understand that errors will be made by health professionals from time to time, and that these errors will most commonly be innocent mistakes. These errors become criminal when, for instance, known good practice has not been followed (so the clinician or professional should have known the consequences of their actions), when an action has been taken without regard for its foreseeable or foreseen consequences (recklessness), or the health needs, circumstances and concerns of the individual patient have been disregarded when an action was taken (also recklessness – no regard was given to the consequences for the patient).

iii. Examples of this might be a clinician or healthcare professional deciding to ‘have a go’ at a procedure or intervention when they do not have sufficient experience or competence, opting not to refer a patient to a more appropriate centre for treatment in line with evidence based practice, or not fully informing the patient and their family of the options and risks.

Many patient or family member respondents agreed with the majority view of the medical profession and argued that the doctor must have intended harm (although not necessarily death) or had ‘deliberate intent’. One patient or family member helpfully explains that… ‘everybody makes mistakes… it’s part of life. When people are ill and need help/treatment they turn to the doctors/hospitals and you have to put your trust in them. You have to believe that they will do everything they can to help you and make you well. They should want to help you and make you well because that’s what they trained for,’ and goes on to say that it is when doctors don’t want to or can’t be bothered to, claiming that… ‘if they don’t put 100% effort in or if they think certain people aren’t worth helping,’ that is what makes it criminal.

Another patient or family member argues that… ‘the vast majority of cases making an unintended mistake is not a criminal act. Healthcare professional’s activities - cutting people open, injecting them with toxic chemicals etc - carry extreme hazards for their patients. The consequences of making a mistake can mean a patient dies. But the severity of the potential adverse consequences does not automatically mean that healthcare professionals will make fewer mistakes than other professions. What it does mean is that those in the
A healthcare provider organisation have a responsibility to recognise that any system of work which relies on human infallibility is not a safe system of work... Where a mistake or mistakes have been made by an individual the initial focus should be on the provider organisation investigating whether the individual lacks competence and whether the context in which the task was being carried out (including the task method) was not as safe as reasonably practical. A lack of competence would normally be addressed by retraining and revalidation. The public may need protecting by removing the healthcare professional from duty until reassessed as competent... referral to the police and CPS would not be the right course of action.’

Many patient or family members highlighted that they believe that dishonesty and lack of openness (eg where the doctor has lied or altered evidence to cover up the error or mistake) is what makes a mistake resulting in patient death criminal. Some say that this includes the doctor not acknowledging the 'mistake' (i.e. incompetence) or where there is 'a deliberate failure to account for errors and omissions'. One patient or family member elaborates on this and says that this includes... ‘concealment of the truth, misleading information given to the family, fabrication of medical notes, cover up of the treatment and care management provided to the patient, complicity between doctors, providing misleading depositions to a Coroner, misleading a Coroner during oral evidence while under oath, providing misleading information to a public inquiry, misleading a public inquiry during oral evidence while under oath, doctors breaching their statutory obligation and professional duty and were self-protection and defensiveness amount to concealment and deceit.’

Another argues that... ‘Duty of Candour was made law in 2015 to make sure that any complaints were dealt with honestly and openly. It is largely ignored or paid lip service to and the CQ[C] who can warn or prosecute over failure to engage Duty of Candour are a waste of time. If this was addressed then there would not be cover ups and Gosport comes to mind. What happened there was criminal and was institutionalised murder.’

One highlights that... ‘If a person did something to a family member at home that put their lives at risk or they didn’t bother to help them and they died or suffered, they would be charged with neglect or murder, so why should doctors get away with it?’

Another family member comments on the Liverpool Care Pathway (LCP) stating that they believe it is still in use as recently as a ‘month ago’ despite the recommendations in the ‘More Care Less Pathway’ report6, and that... ‘each and every one of the "fatalities" caused by the LCP were criminal as many patients were put on the cocktail of drugs and died prematurely and whilst it will be argued the doctor knew what was happening, explain how some patients on the LCP pulled through, went on to recover and went home because loved ones intervened. This practice has to stop and if allowed to continue would be deemed cruelty and therefore criminal as not even vets can predict deaths.’

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Others expand beyond dishonesty and deliberate harm, giving the following factors as examples of when an individual should judged criminally culpable:

- Reckless disregard for patient safety or a ‘reckless nonchalant, bombastic attitude’.
- If they took action which made another individual more likely to make a mistake. For example, aggressive, bullying action on the part of a senior health care professional or manager which creates a climate of fear where a junior healthcare professional feels pressured to act in circumstances where they do not feel competent because of lack of training or experience.
- ‘Assault’.
- Omissions or actions which go against accepted standards.
- A complete failure of duties e.g. ‘doctor on call actually not in building’.
- Knowingly putting your own/colleagues’ interests above the patient’s clinical situation.
- Barely attempting to save someone’s life and then inventing some outlandish excuse for the death.
- Avoidance of use of appropriate reporting mechanisms (eg Serious Incidents Requiring Investigation).
- Blatant disregard for trust safety policies; not following NICE guidelines; failing to ensure therapy/the drugs for the procedure is of a standard approved by the MHRA for that procedure which results in the patient’s death; ‘using own protocol or experience in life saving decisions’; ‘unethical treatment’ or ‘experimental/trial drugs without patient or family knowledge that it is/not consented to’
- Total failure to make relevant and mandatory safety checks when providing care resulting in death to a patient.
- Failure over a sustained period of time to take action or seek senior review when a patient’s condition is deteriorating without significant mitigating circumstances.
- Not acting in the right time to help the patient.
- ‘Obvious neglect’, with some giving the following examples: ‘knowledge of serious situation, yet not prompting urgent treatment or transferral;’ ‘not passing essential information on to colleagues, and in the correct timely manner’; ‘when the drip and food is removed’; ‘abandonment’ of the patient; ‘drugs pump syringe unauthorised inappropriate opiate drugs overdosed- hastened death’; and, ‘no brain stem test.’
- Failure to obtain consent or ‘underestimating patient capacity’.
- Taking decisions without family agreement; disregarding or patronising family of the patient; refusing to listen to relatives or patient who know the medical history; or, to read a patients notes fully prior to treatment.
- Lack of duty of candour
- ‘you would expect a doctor to not make the same mistake a 2nd time or a 3rd time or a 4th time, that wouldn’t be classed as a mistake surely...that is criminal.’

Unlike the majority of respondents in this category who described elements that would make a mistake resulting in death criminal, one patient or family member argues that... ‘It is my strong view that there are no circumstances where a medical or nursing professional should be prosecuted in this manner save for where intent is proven for a wilful act i.e. actually the threshold of murder requiring mens rea.’

One Legal Academic thought that what makes a mistake resulting in a patient death criminal is a ... ‘lack of insight of mistakes made with practice [and] significantly varying from one’s peers and not just a variation on existing acceptable practice’. Similarly, a member of the Legal Profession argues ...‘careless disregard for consequences of their
actions or acting outside of best practice such as performing a ‘risky’ procedure that is not clinically necessary’.

A Legal Academic specialising in medical law, Professor Margot Brazier has helpfully noted that:

‘One of the principal problems for the Review is that ‘medical manslaughter’ and the implications for the specific questions addressed in the Review cannot be divorced from the broader context of the offence of GNM and public attitudes to the extent of the criminal law. In statute after statute Parliament creates more offences based on negligence despite lack of evidence that the criminal law deters error. Public perceptions of crime are increasingly that if a crime has been committed the accused should be imprisoned. The criminal law and process has altered to allow much greater scope for retribution. It is against this background that the Review has to seek out practical measures to address current process.’

In a similar vein Nick Ross comments that:

‘Law is essential to hold any society together but it shifts as society shifts. Therefore the law should reflect society’s understanding of what is morally acceptable or not. Examples of this include motoring offences or underage sex. GNM is therefore one of fashion, factors that turn a mistake resulting into a death are reliant on parliament, judges and to some extent juries, with indirect influence from newspapers and other mass media.’

Another prominent Legal Academic in this area, Oliver Quick explains that in regards to the factors required to amount to GNM:

‘Whilst strictly speaking the law demands attention to the conduct in question, my strong sense is that in reality conduct here stretches beyond the time preceding and during the incident and includes conduct in the aftermath. Any suggestion that the suspect is not telling the whole truth, or worse still has attempted to cover up what they perceive to be damaging evidence, is likely to be critical in the overall assessment of criminality. This is not uncontroversial as it increases the risk that character as well as conduct is being assessed. In other words, perception or evidence that the suspect is not being fully candid and honest will feed into the investigatory, prosecutorial and expert witness assessment. What happens after the incident is often quite powerful evidence which may shape the overall assessment of culpability.’

Legal professionals told us that the following were factors:

- Careless disregard for consequences of their actions
- Acting outside scope of practice/competence
- Knowingly performing a ‘risky’ procedure that is not clinically necessary/Where the risk of death from doing the act or failing to act was such as to be serious and obvious to any competent doctor.
- Where proper and reasonable inquiries would have revealed contraindications
- Knowingly not follow best practice
- Dishonestly and deliberately covering it up, by for example, manipulating the medical record.
- When the four part test of the common law criminal offence of gross negligence manslaughter is made out, as set out in the case of R v Adomako (1994) 3 WLR 288, i.e.
  1. the existence of a duty of care to the deceased; 2. a breach of that duty of which;
causes (or significantly contributes to the death of the victim; and 4. the breach is so severe that it is grossly negligent and, therefore, a crime.

One legal professional elaborates on what they believe ought to be the criminal law, as opposed to what currently is, saying:

‘In my view no genuine 'mistake' should ever become transformed into a criminal act - the question is what removes an act from being a genuine mistake into the field of criminal culpability. The border seems to me to lie where the 'mistake' is in fact a deliberate act intended to do harm or, an act which is known, by the maker, to be taking an unacceptable (and unconsented) risk of death or serious harm to a patient. Such an act would amount to a deliberate disregard for the safety of the patient.

A tired doctor who mistakenly mis-prescribes leading to death, ought not to face criminal action. A doctor who, knowing that the drug or quantity of the drug s/he is prescribing is clearly dangerous and has not obtained informed consent, except in exceptional circumstances where such a prescription is believed to be the only lifesaving option for the patient, should be criminally liable. Similarly with unnecessary operations, known to the surgeon to be unnecessary and to carry the risk of death, unless the patient has provided fully informed consent, should face criminal liability.

Failing to diagnose through lack of medical knowledge or lack of support however serious that failure, ought not to lead to criminal sanction. A failure to diagnose where the doctor deliberately turns a blind eye to that which is obvious might require criminal sanction.’

An advanced nurse practitioner told is that it should include ...‘Premeditated errors or failure to discuss potential problems or complications.’

The colleges suggested that consideration should be given to the systemic issues which may induce criminal liability and would help to determine acts that were truly exceptionally bad (as per Sellu) and those which were just 'mistakes.' Some noted that human factors analysis should be considered as a part of a standardised approach to investigations. There are significant calls for guidance on what acts/omissions and relative systemic issues would lead to a doctor being convicted of gross negligence manslaughter.

Interestingly NHS Improvement tell us that... ‘Within healthcare we commonly advise that the only actions of individuals that indicate referral to the police are those which indicate possible:

- malicious intent (wilful harm or neglect) or
- unmitigated recklessness (knowingly departing from agreed protocols or accepted practice in the absence of mitigating circumstances and in a way in which their peer group would not)

This approach is supported in healthcare by The 'Just Culture Guide' produced by NHSI to assist managers in the just and consistent management of staff when things go wrong. This implies that they advise a higher threshold for referral than the criminal law of GNM requires, in that they suggest indication of the state of mind of the individual (malicious intent or unmitigated recklessness) before referral is appropriate.
Independent review of gross negligence manslaughter and culpable homicide
Question 10. What factors turn that criminal act into manslaughter or culpable homicide?

There were 609 responses to this question online.

A number of respondents drew on the case law of GNM to describe what would constitute GNM, in particular the four stage test laid out by Lord Mackay in Adomako. A number of respondents argued that the common law has deficiencies and in particular that the circular test/threshold making a negligent act, grossly negligent and therefore criminal... ‘appears very open to interpretation and therefore flawed.’

Many medical professional respondents felt that negligence – or a ‘mistake’- was not sufficient enough to be considered gross negligence manslaughter or culpable homicide. The word ‘intent’ was used in responses 118 times, ‘intention’ 51 times, ‘wilful’ 31 times, ‘deliberately’ 25 times and ‘deliberate’ 75 times. There was little difference between the previous question (inclusive of patient or family member response) other than that the majority of respondents felt that the patient had to have died (which may seem an obvious point, however may be important to consider because without that outcome i.e. the patient died, many argue that the criminal law would not apply to the same error/mistake/act/omission).

It was noted that mitigating circumstances such as system pressures or similar mistakes made by other doctors would mean the death of the patient could not be considered as gross negligence manslaughter or culpable homicide.

One respondent noted... ‘the regulatory system should be the first point of investigation (with the caveat that of course they can refer on to the criminal system later if they feel an individual may be criminally culpable). The reason for this is that the criminal system looks at one individual and does not take account of the system factors or understand either the medical complexity, the difficulties of working within a flawed system, the inability to give all your attention to one patient when there are many other patients who are equally unwell at the same time...this is something that the regulatory body is better able to address - and if, after taking the system factors and competing priorities into account, they feel a doctor may be criminally culpable, then they should refer on to the criminal system as appropriate.’

Another respondent draws on their experience of safety policy and implementation in the chemical industry and compares this to the approach in the healthcare sector... arguing that... ‘Applying chemical industry standards to the details of the Adomako case... we would have had much more robust safe system of work. We would not have relied on the anaesthetist to check that the oxygen supply remained connected to his endotracheal tube; we would have adopted hardware solutions that meant that the oxygen supply could not accidentally become disconnected; we would have had an audible alarm to indicate loss of oxygen delivery; we would have had systematic retraining in the emergency procedures to be adopted in the case of failure of oxygen supply. If such an incident had happened in the chemical industry resulting in a fatality it is noteworthy that the company would have been prosecuted by the Health and Safety Executive for not having a safe system of work, not the individuals.’
An Academic advises that the factors which make a mistake criminal are... ‘Persistence on behalf of the individual to maintain erroneous practice or significantly different to current normal practice of peers.’

An advance nurse practitioner believes it would simply be... ‘Not following guidance or making mistakes.’

Some colleges argued that there must have to be intention for a criminal act to be deemed grossly negligent. The Royal College of Radiologists argued that ‘malice or cover up’ would make an act grossly negligent.
The experience of patients and their families

Question 11. Do the processes for local investigation give patients [this should read: families] the explanations they need where there has been a serious clinical incident resulting in a patient’s death? If not, how might things be improved?

There were 588 responses to this question online.

There was general consensus amongst all respondent groups that processes for local investigations do not give patients or family members the explanations they need, or work as effectively as they should do.

This was the first question asking respondents about their experience of local investigation processes and so it yielded lots of responses which highlighted perceptions around deficiencies in local investigations processes generally, as well as responses commenting more specifically on whether they give patients or families the explanations they need. The deficiencies in local investigations identified were mostly consistent across different respondent groups, which included the perceived:

- variable quality of local investigations (with some being better at providing families with explanations they need)
- lack of family involvement in the local investigation process
- lack of transparency of investigations
- inadequate communication with families overall throughout (including failure to share relevant material with families and when documents are shared, letters are very long and often in legalistic/medical impersonal 'jargon')
- lack of independent or impartiality of those investigating/ presence of bias (both for or against individual doctors)
- lack of an independent person/advocate to advise patients – no identified single point of contact
- issues around timeliness of investigations and obstacles which cause delays
- lack of co-ordination between investigatory agencies - police, coroner, internal, GMC to minimise delays.

We were also told by many respondents across all categories, that when an organisation does not engage with families at the earliest opportunity following a serious incident, and fails to respond with appropriate compassion and honesty in response to their questions, it is more likely that the family will pursue legal redress. Many respondents also provided helpful suggestions for improvement of the process which would enable better outcomes in terms of families getting the explanations they need and moving towards a less adversarial system that would enable lessons to be learned. More detail is provided on these themes, below.

Patient or family member feedback was generally of a negative experience of local investigations. Their responses focus on their perception of a lack of transparency by the organisation they have experience of. Particularly, with regards to the process, materials informing, reports following and outcomes (in terms of actions taken), to the extent that it has caused their perception that the organisation concealed issues that might damage its reputation. They do not feel local investigations are impartial. We also heard from medical professionals as well as families/patients, that healthcare organisations rarely admit any
responsibility- ‘trusts tend to bring down the drawbridge rather than involve families with the process.’

In addition to the above themes, medical professionals highlight in particular, the perceived lack of organisational recognition of the second victim and support for healthcare professionals involved in investigations. Doctors also overwhelmingly reflected a perceived threat of criminal sanctions for getting something wrong (and/or of litigation). They also highlighted their view that individual doctors are blamed or that there is a blame culture associated with the local investigation process. Some claim that local processes seem ‘designed to protect the trust’. We were told that...‘full admission of mistakes and causality is seen as dangerous and likely to result in blame and personal damage - to career, reputation and livelihood.’ They also said that...‘in an adversarial system it is for the doctors, their defence societies and the Litigation Authority to fend off actions if they can. No one can seriously believe this encourages clinicians to admit mistakes.’

There were also some comments from medical professionals suggesting that individuals are actively discouraged from reporting incidents, and/or threatened, for example a respondent argues that ...‘Junior doctors are still generally discouraged from admitting to ignorance (I recently heard a consultant reprimand a junior: 'you ought to know that!') and talk of 'Brownie points' for not bothering their consultants...They are called junior doctors because they are technically in training but in reality are front-line troops. This is not conducive to owning up to error.’

Some medical professionals make the point that, ‘the media doesn't help’ - claiming that ‘media coverage of patients or families who can't accept loss is one-sided.’ Many medical professionals also highlighted the lack of training or expertise of those investigating.

A number of respondents (from all groups) commented on the lack of independence of local investigations, saying that...'Because the process is local, there is no getting around the feeling by patients and relatives that the investigation is biased’... ‘internal investigation means potential for internal bias,’ and... ‘a root cause analysis should be done independently (not by an institution that needs to protect itself, such as the trust)’. They go on to say that ... ‘There is a potential conflict in that those involved in local investigation may well be liable for prosecution in criminal case. Fear of incriminating oneself may inhibit full reflection and disclosure.’

In evidence of the perceptions of lack of independence of internal investigations and the damage that can be done from not getting it right first time, we were told by a medical professional that they had been involved in ...‘serious clinical incident reviews of deaths in other departments...where often a complaint has come in and been dismissed (due to a lack of independent review) and subsequently [they] have been part of a series of deaths reviews - this is immensely distressing for families (having been told that there was nothing wrong, and subsequently that a critical error/errors have occurred).’

Royal College of Pathologists told us that... ‘The result for patients relatives are variable as is the quality of internal investigation which can vary from Trust to Trust and Department to Department. Poorly conducted investigations can make a bad situation worse and damage relatives and healthcare professionals.’
Many respondents stress the need for timeliness and avoidance of delays in investigations. They say that earlier communication with family members is required, and for the organisation to explain the process of the investigation and time it will take. They say that giving family members a realistic timetable for the investigative process ‘will help prevent the exhaustion that comes of waiting in limbo for events to transpire. It will maintain levels of trust which are key to rapport and on-going dialogue. Investigation is slow, which can be frustrating for patients and the delay may suggest a cover up.’ Some claimed that the ‘slowness of response’ is what seems to ‘frustrate families the most.’ A number of respondents explained why the process of investigation takes considerable time, providing the following examples of influencing factors:

- it needs clinicians to take an active part but they often do not have the allocated clinical time to do this
- lack of administrative support
- obtaining consent
- writing reports
- *only* communicating in writing
- gathering the necessary information for the clinical reviewer to consider (from multiple parties)
- inviting further information/reflection from both parties.

We were told that...‘following an avoidable death, a family wants to know what happened, why, what is being done to prevent recurrence and if appropriate an apology. And they want it quickly - most families start off without recourse to solicitors. They resort to the legal profession to get to the truth if they are not getting answers from the healthcare provider and feel they are being fobbed off. The primary motivation is usually to get to the truth. It’s not usually about money.’

The Patients Association support this assertion as they tell us that...‘the most common reason for patients contacting...[their] helpline is to ask for advice on how to make a complaint or how to proceed when they are not happy with the response they have had to a complaint. Where patients have not had an explanation that answers their concerns this is often because they have not been fully involved in the investigation...Occasionally we have heard from patients that they have not heard anything until an investigation report arrives through the post’.

Similarly, NHS Providers point to a number of reports which say... 'that when an NHS organisation does not engage with families at the earliest opportunity following a serious incident, and fails to respond with appropriate compassion and honesty in response to their questions, it is more likely that the family will pursue legal redress'. They highlight that in addition to the harm and distress this causes families and doctors, ‘the rapidly escalating cost of NHS litigation is unsustainable.’
Again, NHS Improvement also highlight that... 'there is 'compelling evidence from patients, families, carers and staff that has revealed weaknesses in the way NHS organisations investigate, communicate and learn when things go wrong... Improvements could be made by ensuring there is early and meaningful communication with families, supporting their needs, and facilitating their involvement in any investigations that are undertaken. However, there are multiple reasons why this does not currently happen (including lack of time and appropriate skills, and a generally defensive and closed culture across the NHS). Work to understand how to overcome these issues is being explored through work on the review of the Serious Incident Framework. Organisations such as HSIB [Health Service Investigation Branch] and PHSO [the Parliamentary Health Service Ombudsman] are also working to improve how the system responds to incidents and complaints (where safety concerns are raised) more broadly.'

A legal professional adds to this feedback, saying... 'my experience of bereaved families in cases of this type is such that the initial lack of openness and legalism engenders a mistrust so deep that their conviction of the concealment of wrongdoing can never thereafter be displaced.'

Some medical professionals raise their 'suspicions that families are besieged by lawyers wanting to go for negligence claims, and managers trying to avoid that, without having a neutral person who can explain the events to them in lay language and who can explain the process and findings of investigations to them.' They also say that root cause analyses, clinical incident analysis and clinical records are often not what is presented to families by the healthcare organisation doing the investigation. They add that the serious incident reports provided to families often lack details and argue that the sharing of all of these documents, with adequate explanation of them in plain English would be beneficial.

One patient and family describes their positive experience... 'some Trusts are commendably open and forward looking in their approach, involving families in investigations and in helping design an implement improved systems of work... Following my son’s death I was "lucky" in that once I made it clear that the family were not interested in litigation the consultant was commendably open about what had happened and why. He also apologised. This helped me and I believe the healthcare staff involved. From talking to other families over the years it is clear that there is huge variation in the way incidents are investigated and families are treated. This issue is being addressed by the Learning from Deaths Review being organised by NHS England.'

This respondent goes on to highlight that... 'The adversarial legal process is ill suited to the needs of the families and the needs of the provider organisation to learn the lessons from an incident so as to improve the safety of patient care. The tort system appears to be focused on finding out if there was any one who was at fault and should be blamed. Pinning the blame for an incident on one person absolves the organisation form investigating and finding out why that individual acted as they did and from the duty to learn how the overall system could be made safer.'

There was suggestion from a number of patients/family members and some doctors that another primary driver for families (or patients) wanting answers to their questions is that
they want reassurance that lessons have been learned and systems altered to ensure won't happen again. It was argued by some that they believe the legal route is damaging to this. Also, they highlight that embedding changes to enhance patient safety following organisational learning may take time, so it is important to make sure that the patient/family have this properly explained to them and are fed-back to once improvements are implemented.

We were told that local investigations lack face-to-face discussions with the family and that there are 'barriers between clinicians and patient/families.' They say that meetings with clinicians are important to provide full explanation to family members and to answer their questions. We were told by one family member that the lack of contact with the clinicians was worsened 'when the CPS became involved.' Another medical professional respondent told us that...‘Often, the advice families get in the early stages is given by people who are experts in the management of concerns, without any involvement of experts in the field where the concern occurred. These people give a well-intentioned emphasis on taking the concern seriously, which can re-enforce the complainant's conviction that something untoward has happened, whereas a conversation with an expert in the field (who wasn't involved in the actual case) will often educate both the complainant and the concerned handler and result in an early fizzling-out of the concern.’

One patient or family member made the point that...‘The trust has in our experience been very good at providing information regarding the drug error that caused our son’s death, however, very little information is given to the family by the trust regarding the processes of disciplinary action. Families are not allowed any involvement in the disciplinary processes and are not informed of the outcome of any disciplinary action....From personal experience it is the latter that drives a desire for a criminal conviction, with a criminal record it will be recorded and will warn any future employer.’

**Suggestions for improvement**

Many respondents made helpful suggestions for potential improvements to ensure patient and family involvement in processes following serious clinical incidents including the views that:

Instead of an adversarial process it would be much better if families could be treated as partners in any investigation. Further, to make the process non-adversarial - just seek the details of what happened and why this led to the death.

An open transparent approach would help retain trust and foster cooperation. Ideally an approach should be developed based on 'Truth and Reconciliation'. This is a council of perfection and it must be acknowledged that some families will feel very angry about the death of their loved one. This will be particularly the case where they and their loved one have been treated poorly prior to the patient’s death. Being angry and wanting someone to be held to account and punished is perfectly understandable and in some cases will be difficult to reconcile with an open learning just culture.

Patients and family members told us that they believe the serious incident investigation should be undertaken by an external party. They claim that independence from the
organisation where the event occurred might provide families with more reassurance and provide more confidence in the investigation...’thethe provider could work with an independent investigator (perhaps from another organisation) in order to avoid conflicts of interest.’

Patients and families also want to be actively involved and to understand the process, saying...‘They should be given the opportunity to agree the process or suggest changes. There should be the opportunity to ask for an external investigation if evidence can be provided that the internal one has not answered all the questions posed.’

Some responses from all respondent groups say that the investigating organisation should provide better information to family, including transparency about process and timelines for investigation, and explaining the systemic factors at play and the complexity of medical practice. Whilst it is recognised as important to provide families with explanations, some respondents claim that ‘...there can be a tendency to explain too much and listen too little.’

Generally, respondents stress the need for investigations to be open and transparent - they say more could be done to speak openly and honestly with the family for example having a group meeting with the family during, as well as after, the investigation and more fully explore their views. Another suggests it could be improved through facilitation of meetings between the doctor and the family.

In relation to the composition of the investigation team, respondents made the following suggestions, that:

- the party communicating the explanation should have no close working relationship with the team involved in the care of patient who died....This will ensure that relatives get an unbiased explanation as much as possible.
- There should be involvement of staff with the 'right expertise' (both in terms of specialty in question, and training in investigations) and independence (although some highlight challenges with this from a practical level). The Medical Schools Council (MSC) say that it would be...’helpful to develop appropriately trained staff and support teams,’ and that... ‘MSC will address the student training issues with the education leads over the next 12 months.’
- The BMA recommends that there is a family representative available, who is able to provide appropriate explanations to families and carers. ‘This representative should be involved early in the process to clarify questions for medical staff and the Trust and also establish which questions the family want to be asked.’
- There should be external consultant representation from specialties relevant to the care the patient had received to determine if practice was outside "the norm" for any involved practitioners. This is important to see if the error(s) are due to the practitioner(s) and/or the institution.
- There should be involvement of lay representation in investigations.
- There should be protected time for involved parties in investigations.
- There should be mediation / independent adjudication - After a local investigation is completed, if the affected parties are not happy with the outcome, there needs to be an expert impartial investigation with legal and lay involvement to prevent the feeling that 'doctors just stick together'
Other respondents provided other suggestions for how all local investigation processes could be improved:

- There should be less protracted process for minor incident investigation so that focus can be on major incidents.

- There should be a national strategy for how to report local investigations of death so they are standardised (including how serious incidents are categorised, escalated, investigated and learning disseminated). The Faculty of Pharmaceutical Physicians, (RCP) say that ...'It would be valuable to have National authoritative guidelines on the management of deaths through medical mistakes, perhaps a task for the Academy of Medical Royal Colleges or the GMC. Interestingly the idea of National Guidelines and associated training of hospital staff was proposed some 9 years ago by Fallowfield*' (*Lesley Fallowfield and Anne Fleissig A report requested and funded by the National Patient Safety Agency and commissioned by Professor Richard Lilford. 2009)

- There should be better co-ordination between investigatory agencies - police, coroner, internal, and the GMC to minimise delays.

- ‘If it [the case] is considered serious enough for Police involvement, the investigation should be jointly taken by the employing authority/CCG, the GMC and the Police...A decision should be made whether a corporate manslaughter charge would be more appropriate than an individual.’

- Make all investigations public.

Much like the responses to the previous questions about, what people perceive to be ‘criminal acts,’ there was again, a call from medical professionals to remove the threat of criminal prosecution, unless there was intention to cause harm. There was also some who highlighted the system in Australia, where they say that doctors who raise concerns are afforded some form of legal protection. A number of respondents referenced the ‘no fault compensation’ system in place in other countries. They say that ...‘Having no fault compensation for people injured by mistakes could help a more open and supportive culture’

They say that a rapid and thorough assessment of all the circumstances should be undertaken by experts and the "accused" person informed if they are deemed negligent and liable to prosecution or not. Those assured of no prosecution should then feel able to give a full and frank disclosure to the patient/relatives. They say that...‘If the law was changed such that criminal sanctions would only apply if criminality was clearly present then this might reduce the fear that organisations have over full disclosure to patients and their families, such as that found in New Zealand for example.’

A few suggestions were made, for having all fines/awards for patients/families from a central pot, and/or for ‘A Swiss style system that deals efficiently with compensation for medical negligence outside of the legal system...This reduces overall cost of compensation and negates the need for lawyers in the medical negligence system and would likely speed up the process which would be beneficial to all parties.’
• Ensure meetings give enough time to explore all the issues
• Ensure that plain English language is used in all communication with families
• 'By allowing the family to pose the questions that they most need answering.'
Question 12. How is the patient’s family involved in the local trust/board/hospital investigation process and in feedback on the outcome of the investigation?

There were 516 responses to this question online.

114 online responses said they did not know or words to that effect. Based on the responses to this question, there is clear variability in how or the extent to which families are involved in local investigation processes. There was a split response, with a significant proportion who indicated involvement, including some good practice. Conversely, a significant proportion said there is little, to no, involvement of patient’s families in local investigations. Many respondents referenced the duty of candour in response to this question, which is the professional duty for a professional responsibility to be honest with patients when things go wrong.

Methods of involvement of patient’s families highlighted in responses included:

- The Patient Advice and Liaison Service (PALS)
- Coroner’s Office or attendance at the Coroner’s Court
- Leader of Significant Event Analysis meeting
- the complaints process
- the patient participation group
- NHS England
- the CCG
- specific local inquiry panels (depending on the source of the complaint).
- the local CDOP death reviews.

We were also told that... ‘the commonly used [root cause analysis] RCA template asks for a description of how the family are involved. The duty of candour means that they should be informed. I am not aware, however, of any best practice guidance of how this ought to be done.'

In good practice examples provided by respondents, families are fully involved in the serious incident review and the process was made transparent to them: their input is taken account of, they meet with clinicians and receive regular communication. The consultant debriefs the family immediately and a duty of candour letter is sent immediately. Families are seen at the start of the investigation, are firstly informed that an investigation is going to take place and what format this will take and are asked to help shape the terms of reference. There are multi-disciplinary meetings with the family. They have full access to the documentation throughout - they are given the opportunity to see the draft report before it is published, oversee the action plan and are able to respond to the various statements.

We were told about a number of local investigation processes by medical professionals, where they say that at their healthcare organisation, a ...

‘patient’s family is interviewed and their views are included in the report. They are given feedback after the investigation.’
Another says that families are ‘...invited to contribute to a significant event analysis if appropriate and if a mistake is deemed to have been made they would be informed.’ Another says that they are ‘interviewed so that they actively take part in the investigation process and can provide questions, they want the investigation to answer’... ‘All communications are documented with relatives receiving a copy. Relatives are invited to receive feedback from investigations if they wish so.’ ‘Sometimes these cases are presented at Trust Open Board meetings which families are invited to attend.’

According to one medical professional, they have ‘...dedicated patient safety teams who contact the patient’s family early on and ensure an external review process is carried out in a timely fashion with involvement of the family and a culture of honesty and openness which is supported by the consultants.’

One medical professional states that their local policy works well for them and explain that they ‘...have had cases where families want to discuss what happened in the last few weeks to get a better understanding. We invite them in to have a look at the notes and then discuss things with the doctor, practice manager and occasionally a district nurse. That meeting is summarised in a letter to the patient’s family offering more clarification and another meeting/ how to take things further such as ombudsman if they are still unhappy... At our next significant events meeting any learning points will be shared with the whole practice team.’

One respondent referenced death in custody reviews as good practice ‘...the PPO asks family members for questions they would like answered-whenever possible-regarding the passing of their loved ones.’

Health Education England told us that... ‘The model for investigation of deaths for those with learning disabilities should be followed for all deaths. In other words the family should be involved but it should be clear that the investigation does not aim to apportion blame rather it is looking to prevent harm to future patients.’

NHS Improvement say that family involvement in investigations should be as per the Learning from Deaths guidance, but that there has been ‘...variable implementation of it.’

A lot of respondents indicated that families are not involved appropriately or don’t have direct involvement as per the process, and are often: only sent final report; or, only have a face- to face meeting to discuss the final report; or are given ‘passive involvement.’ We were told that the following were key issues in this area:

• Families ‘just get a standard letter with no admission of any mistakes or errors. This can often inflame the situation as the family perceive the response as evasive.’
• Investigations only take place when there is an incidence report or route cause analysis as a result of a serious mistake. A lot of mistakes are not openly discussed with the family otherwise. Even after a root cause analysis, patients or families do not get any feedback unless they have made a complaint. This culture need to change.
• ‘All too often kept at arms-length because of the fear of litigation ‘
• Families ‘are excluded in fact - and are presented with findings and conclusions without having helped shape these. It is quite disempowering.’ With some claiming that interaction with the family is actively discouraged and ‘...when meetings with family are conducted this task is "outsourced" to our Clinical Risk
Team or Medical managers and there is limited opportunity to meet with families directly.

- It is usually the staff involved that have to find time (often in cramped rooms) in busy wards to explain the process.
- Often people talking to the family do not have the appropriate medical experience to explain the issues effectively. They say that these cases usually involve medical issues ‘but the clients are not represented, or may be represented by lawyers who do not understand the medical aspects of the case.’ Peers or medical experts are rarely involved.
- The duty of candour lead will share information, but if they were not involved in the treatment of the patient they may not be able to answer wider questions.
- A few respondents indicated that protocol is followed above all, ‘often at the expense of empathy’.
- PALS is not always seen as helpful, with some claiming that their ‘lack of independence is an issue’.
- Similarly, because ‘Independent Medical Examiners’ will be employed by the Hospital they could struggle to gain credibility and the trust of grieving families.

As was highlighted in many answers to the question preceding this one, the Law Society of Scotland flagged the potential impact of failure to involve families appropriately, saying ‘...our position is if these are not dealt with appropriately and effectively, there may be more likelihood for greater Crown Office and Procurator Fiscal Service (COPFS) involvement as matters will not have resolved at the first opportunity.’

In terms of the issues with family involvement in local investigations and suggestions for improvement, many responses echo/reiterate the feedback in response to the previous question (11):

A medical professional flagged the issue with time it takes to conduct investigations and how families have not always been satisfied with the speed of response in their experience, but that ‘the clinical team involved are all trying to do full time medical jobs and complete the investigation at the same time. Therefore it is done as it can be fitted around clinical practice.’

Similarly, the Royal College of Obstetrics and Gynaecology (RCOG) told us that ‘feedback...on the Duty of Candour shows that it is well known and understood as a formal way of speaking to families after a serious incident has occurred. However, Duty of Candour alone is not a sufficient driver for the involvement of families in an investigation to understand what went wrong. In order to fully engage patients and their families during an investigation, departments and clinical staff need to be properly resourced and receive training into how to facilitate an open and transparent conversation. This will enable clinicians to approach issues of clinical error with more confidence and skill and ensure that they understand the value to their working practice.'
The British Medical Association (BMA) adds that ‘In England, most Trusts have processes and guidance which implement the national framework at a local level; however, there is a lot of variation and inconsistency in implementation. Despite Trust policies on family involvement and support being in place, many Trusts were reported to the CQC as not involving families or carers in the investigation process. When families were involved, they were not happy with the level of involvement. Families and carers can offer a vital perspective in helping to fully understand what happened to a patient as they see the whole pathway of care the patient experienced, which clinicians conducting the investigation may not have seen. The BMA sees family involvement as an essential part of the investigation process and believes this must be embedded, particularly by using families’ perspectives as evidence for the investigation.’

In relation to the approach in Scotland, Healthcare Improvement Scotland told us that ‘Communicating effectively with people is a vital part of dealing with errors or problems in the delivery of care. Saying sorry, providing an explanation and keeping them informed will help people cope when things have gone wrong. The national framework advocates that the organisation should give early consideration to the provision of information and support to patients, service users, families, carers and staff involved in the adverse event, including details on available support systems. We have developed a suite of national leaflets which can be used as a support tool. We have also published a reference document for Scotland that builds on the principles within the National Patient Safety Agency’s (NPSA) Being Open Framework (2009) to support care providers develop their approach to communicating and engaging with people who have suffered harm following an adverse event. These tools are available on our Community of Practice website. This approach aligns with the Duty of Candour procedure.’

A couple of patients or families reflected on their positive experiences, saying:

- We were invited in for a meeting to be told of a possible error, we then received this in writing. We were contacted by phone before hand to warn of the letters arrival which did help when receiving it.
- We were invited in for meetings to discuss any questions we had from the report. We felt the investigation and the lessons learned following a serious incident investigation were acceptable and felt confident that numerous changes made meant that staff were now less likely to defer from the medicines policy in this way again.

However in the main, families or patients suggested that in their experience, their involvement in the investigation process was inadequate, and expressed a desire for patients/families to be more involved - with more regular contact, more transparency and better updating on the outcomes/what has changed as a result. This in some cases had left patients feeling disappointed and let-down, and in others to suspicion of a cover-up. The following extracts demonstrate this:

- ‘It can be at times slow to release a finished report until it has been to top level executives and approved. This is in some ways worrying as changes at an executive level after completion do make you wonder what they do not want to say.’
- ‘We were unhappy with the apparent dismissal of our legitimate concerns regarding the staff involved in the error. These concerns had come to light during the interview process by the investigators. Whilst they agreed with our concerns they offered no assurances
that they would be dealt with along with the drug error. We were offered no help or support in addressing these concerns or being given an outcome.’

- ‘We only met closing of ranks....threats to remain silent’

Feedback from Doctors Association UK supports the views of patients/families, saying ‘...although many trusts report that they value family involvement and that they have robust policies and processes to support it, many families report that they have a “poor experience of investigations and are not consistently treated with respect, sensitivity and honesty.”’ The CQC Learning, candour and accountability report goes further to state that “families are not always informed or kept up to date about investigations – something that often causes further distress and undermines trust in investigations.”

A small minority of doctors suggested, conversely, that patients were too involved and ‘put undue pressure on the impartiality of the process.’ They suggested the need to keep them out-with investigation to ensure objectivity, as ‘...this needs to be a review of facts and expert opinion, rather than thoughts and emotions, which might hinder an objective investigation into events.’ Another says ‘this is very difficult. As clearly they need to be informed but how involved can relatives be before final outcomes are known? This is especially difficult with social media. The police do not tell relatives intimate details of investigations or ask them to contribute, what is the difference in healthcare?’

One suggestion is for families to be provided with independent help from a charity like AVMA . This would need to be centrally funded.
Question 13. What is the system for giving patients’ families space for conversation and understanding following a fatal clinical incident? Should there be a role for mediation following a serious clinical incident?

There were 536 responses to this question online.

Some comments suggest a system is in place, and examples of the types of systems are given below. However many more suggested there isn’t a system, or that the systems in place are inadequate. General consensus is that effective systems are needed. The BMA say that space for conversation and understanding ... ‘should be part of the professional and statutory duty of candour....Assuming candid conversations are taking place then a meaningful dialogue should be taking place...Additionally, it is vital to recognise that involvement in a serious clinical incident is an emotionally draining experience for members of staff involved and as a result, they may not always provide consistent and clear responses in the heat of the moment. ...The BMA believes that members of staff involved in a serious clinical incident must be given the space to gather their thoughts before they participate in any investigations.’

NHS Providers’ submission is based on feedback from trusts, and highlights good practice, including specific strategies trusts are taking to address shortcomings, including investment in bereavement support services, and increasing numbers of full-time family liaison officers being established.

Examples of systems currently available for giving families space for conversation and understanding included:

- The Patient Advice and Liaison Service (PALS) - with the Royal College for Paediatrics and Child Health noting that ‘...local PALS services should act for the interests of families and patients and advocate for them as mediators...There should not normally need to be a role for an external mediator. The effect of PLAS on local services should be part of CQC inspections processes.’
- An appointment offered to families with consultant or medical team
- clinical incident reporting
- Complaints officer coordinates meetings and engages with all relevant clinicians.
- written communication,
- the Parliamentary and Health Service Ombudsman
- ‘legal avenues’
- bereavement counselling or counselling support services
- feedback following the post-mortem examination
- Patients complaints groups, who we are told are ‘excellent’ in one trust. ‘The staff are sympathetic and fair but not enough and as well as this you need to then free up time for the clinical staff involved.’
- procedures instigated by the CCG/ Commissioners.
• A bereavement manager or the bereavement office, who were told, tend to be seen as neutral by relatives. Clinicians ask the office to ask relatives about any concerns about medical or nursing care at their first contact, and any information provided is fed into the primary mortality review, at which we make a decision about whether a full Structured Judgement Review (SJR) is required. Any case where concerns are raised via this route will automatically require a full SJR, irrespective of whether a formal complaint is received or not. We are in the process of designing an information leaflet for relatives to explain our Mortality review process, so that they are aware of the review process, and how they can interact with the process.

• a dedicated patient safety team (who along with the senior clinician involved in the incident, are available for the family as the family feel able to speak to them.)

A number of the suggestions for improvement reflected those suggested in responses to the two preceding questions. For example, there were a number of responses reiterating that there is ‘scope to invite families to be directly involved - if they wish - in a serious incident investigation. This would considerably increase their understanding of why the incident happened and perhaps in most cases might dispel a need to castigate individuals.’ Or, ‘there should be proactive mediated discussions with support for family and the clinical teams involved.’

As before, we were told that ‘there should be an RCA [root cause analysis] by an independent person and outcome should be a detailed conversation to explain what has gone wrong.’

One medical professional tells us that...‘There isn’t a formal system locally for staff to follow. On reflection some guidance on how to best do this would have been very useful when talking with a family after such an event. As I can imagine that having many different health care workers giving information to a distraught family at separate times could lead to mixed messages being delivered and ultimately misunderstanding and distrust. So the simple act of appointing one person to act as spokesperson for all agencies would be a simple improvement on our current local systems.’

Health Education England propose that ...‘The model for learning disability deaths should be followed for all deaths. Mediation would then only be needed for a small minority of cases.’

Point of Care Foundation suggest that ‘...healthcare staff, including the senior caregiver, may not necessarily have the skills required for good communication or be in a position to give patients real assurance that the organisation will tackle the underlying problems and the incident will not recur. Healthcare staff, including the senior caregiver, may not necessarily have the skills required for good communication or be in a position to give patients real assurance that the organisation will tackle the underlying problems and the incident will not recur.’

**Role for mediation**

In relation to the potential role of mediation in this context, there was a split opinion. Mostly the feedback was that the nature and role of formal mediation (a method of alternative dispute resolution) is not appropriate in this context, although there was general
A consensus for bringing together patients or family members and clinicians and the healthcare organisation for facilitated discussion (as early on as possible).

Respondents say that ‘families need to be gently supported through the process and everything explained, preferably by one point of contact. System error is hard for families to understand.’ ‘A frank and full discussion is required.’

A few respondents had concerns stemming from a perception that mediation suggests confrontation or represents a confrontational/adversarial system and therefore it ‘isn’t a good idea.’ ‘The family have done no wrong. Mediation implies that this is an adversarial circumstance us against them. We are on the same team and the interests of the patient and their loved ones should be the only important factor. A role of a third party for mediation or consultation should only be where there has been a breakdown in relationships/loss of trust.’ Respondents argue that the focus should be on: ‘eliminating blame culture, establishing a human factors approach and transparency’ which they believe would obviate the need for mediation. In the interim, however, they recognise that ‘mediation may be useful in some cases where distrust and conflict has arisen.’

Respondents say that the function of mediation is different to the role of the investigation - it is about compromise rather than determining facts. It is for ‘an independent person allowing two parties to problem solve and negotiate a mutually satisfactory endpoint.’ Some say it implies that the process has been unsatisfactory, and/or that it is only required where relationships have broken down at the investigation stage – ‘if there is a need for it, the implication is that the explanations given were not to the family's satisfaction, which is sad and implies a deficiency in the way the information way given.’

Similarly NHS Improvement submit that ‘...there may be a role for mediation but this is a strategy that is typically used where there are disputes or where relationships have broken down. Ideally there needs to be a focus on building and maintaining relationships (to support trust and confidence) from the outset so that the lack of trust and dispute that warrants mediation can be avoided.’

Some respondents say they are ‘not sure this is a helpful process where a death has occurred as the process is not one of negotiation. The outcomes of an investigation are not negotiable (an error occurred or it did not, and if it did, the processes leading to that error need to be understood).’ A qualified mediator tells us that ‘...Mediation is not about discovering truth - it is about reaching a compromise which both parties grudgingly accept. Accordingly it has no place in securing understanding.’

Other reasons given against a role for mediation included:

- That it is unnecessary as appropriate functions/recourse for patients or families already exist, i.e. for them to 'contact the ombudsman or parliamentary representative if mediation is required.' We were told that ...‘If PALS is effective [they] would not expect there should be a role for another system.’
- Another respondent argues that mediation is 'rarely a positive process where there is a serious power imbalance. And in conflict with a person, the system always wins. The role of the mediator (as distinct from a conciliator) is to find a compromise acceptable to all parties. Which leaves the individual vulnerable, as they are more likely to find themselves compromised. Even though it's a compromise they ultimately decide to accept.'
• One respondent comments that ‘...Mediation does not give compensation. You cannot mediate with corrupt unregulated Foundation Trust managers: they are often responsible for the wrong understaffing leading to the death in the first place.’

Although there were issues associated with the role of mediation outlined above, there was also a lot of support given for the role of mediation, form doctors, patients, families and stakeholders alike. NHS Providers advocate that ‘evidence suggests alternative methods of redress such as mediation can significantly reduce distress and costs for families, support staff and reduce financial burden on the NHS, these should be explored, with any necessary adjustments made in the regulatory approach in order to facilitate and enable it.’

The Faculty of Intensive Care Medicine agree, adding that ‘...Mediation is useful where there is dispute about the conclusions of the investigation process. The Canadian Centre for Elder Law published a report in 2012\(^8\) showing that 90% of participants of mediation benefit from mediation, even where resolution has not occurred.’

Some respondents went so far as to say that mediation would be an ‘excellent idea.’ Reasons given by respondents in support of mediation include that it:

• May help to break-down barriers/ perceived barriers which undoubtedly develop between parties.

• May help manage expectations of family from outset.

• May be very helpful to assist families in understanding when there has been a fatal incident due to systemic issues rather than an individual's single error.

• Provides an independent advocate for the patient – ‘where a dedicated person guides them through the process and is their link to the investigation etc.’

**Patients and families**

Responses from patient and family member responses indicate that there is little to no experience of mediation, and broadly they agreed that mediation has a role, and should be offered to patients/families (although they may not always want/need it for their specific circumstances). For example one family member says that:

• ‘In our case mediation was not required regarding the drug error that killed our son, the trust was open honest and forthcoming with an explanation. We have however found a serious reluctance by the trust to admit that the consultant caring for our son before the event that killed him was negligent in providing him an acceptable standard of care....For this area of the investigation mediation may have been helpful, however the trust have made efforts to gain more opinions rather than just shutting down the investigation and us needing to contact the ombudsman.’

Another family member tells us that from their personal experience following their 'husband’s death, the health provider simply brought down the shutters'. They tell us that

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\(^8\) https://www.bcli.org/project/elder-and-guardianship-mediation
‘...There should be some kind of mediation following serious clinical incident. Unfortunately form personal experience there is nothing except silence, a wall of silence.’

A number of respondents who agreed that there is a role for mediation highlighted the need for mediation to be conducted by an external/independent and appropriately trained/qualified individual. We are told that mediators need to have, ‘sufficient understanding of the complexities of modern medical care and of how systems influence what happens as well as individuals.’ One respondent told us that they ‘believe it should be undertaken by a highly skilled psychologist or psychotherapist.’ Arguing that ‘...Mediation by individuals without a high level of training is worse than no mediation.’ Further cautions on the use of mediation and how to make it effective in this context included:

- NHS Education for Scotland (NES) believe that ‘there may be a role for mediation, however it is also important for all clinicians involved to provide a clear explanation under their duty of candour.’

- Royal College of Physicians and Surgeons Glasgow ‘believes that involvement of people whom the family know and trust is vital if this is to succeed. Mediators may be helpful but must have the trust of all concerned.’

- Faculty of Intensive Care Medicine (the representative who drafted their response is reportedly a registered mediator specialising in healthcare mediations) tell us that ‘...in order for mediation to work, mediators need to be truly independent of the investigating organisation and have experience in both law and medicine. There is only a limited pool of such individuals, and it is difficult to see how this pool can be expanded to cover the total NHS. It is suggested that mediation should be encouraged where there is disagreement between the family and Trust/Health Board about the conclusions of an investigation. More could be done at an earlier, local stage around the processes of investigation involving the relatives that would allow mediation resource to be concentrated as outlined above.’

- Royal College of Obstetrics and Gynaecology believes ‘there are some instances were mediation would be welcome and appropriate following a serious clinical incident, and that this could be developed as a skillset within trusts and health boards. However, it will sometimes be important that clinicians and families have space away from the hospital to discuss incidents, and there may also be occasions where there has been a breakdown of communication between a family and a trust or health board. In these situations external mediation would be welcome, especially if it can reassure families of the robustness of a local investigation and prevent it escalating into a criminal or regulatory investigation where it otherwise might not have been.’

- Royal College of Anaesthetists ‘...urge caution, however, in the use of mediation for cases involving serious clinical incidents and deaths of patients, especially in cases where the Health Service Safety Investigations Body is called to interview staff involved in incidents under the provision of ‘safe space’ as proposed in the homonymous draft Bill currently going through parliamentary scrutiny. We recommend that the review panel wait for the Joint Committee for this Bill to report on how ‘safe space’ might be applied by the Health Service Safety Investigations
Body in its investigations, before making recommendations on the use of mediation in these rare and complex cases.’

Other respondents caution that funding for mediation is required, that medical professionals would need to be supported/’protected’ throughout and that there is also debate about the appropriate time for mediation. Some suggestions that it should be early (to enable families to ask questions shortly after the death), but conversely comments highlight that it must be at the right time, which could be later:

- ‘not sure of the time frame -too quick and we risk being seen as insensitive.
- ‘introducing mediation too early might result in an unhelpful divide between grieving families and distressed health professionals. It might be helpful for Trust Complaints Teams to have access to mediation.’
- ‘Grieving families may be too shocked and numb to ask questions in the immediate aftermath. They should always have the opportunity to discuss, even weeks and months afterwards. The 'champion' could play a role in mediation.’
Question 14. How are families supported during the investigation process following a fatal incident?

There were 476 responses to this question online.

The vast majority of respondents feel families could be better supported in the investigation process. Responses indicate that there is wide variability between the support provided in different local trusts/health boards. A significant number of responses indicate that there isn't any support. Examples of support services that are available in some included:

- Charities (eg SANDS, AVMA)
- PALS
- Bereavement Officer
- Named person to liaise with family
- risk manager or the matron/senior nurse acts as a point of contact and support
- Senior clinician or senior nursing lead
- Direct contact from GP/practice manager
- complaints and improvement department
- patient involvement officer/ hospital patient and family advice service / patient affairs/ family liaison
- bereavement midwives and a named consultant obstetrician, neonataologist or both
- non clinical member of staff directly involved with the family which can help considerably in the communication between family and the organisation
- Bereavement or counselling support services
- Patient/family GP often involved in supporting families, despite lack of involvement and knowledge of incidents (eg incident may be in secondary care).
- Most support is from coroner's office

Methods of communication/providing support were variable, but included:

- Phone call
- Meetings
- Medical report
- booklet, to explain to families about when and how they can register a death, and about the coroner

In relation to GMC investigations, we were told that they 'operate a Patient Liaison Service, which is for anyone who is a patient, relative of a patient or a member of the public who has raised concerns about whether a doctor is fit to work and we have decided to
investigate those concerns. Meetings are offered at the outset of the investigation process to:

- Ensure we understand the complainant's concerns
- Explain the investigation process and the outcomes available at the end of our investigation
- Make sure they understand what we do
- Signpost them to other organisations that may be able to help where we can't

Meetings are also offered at the end of the process to explain the outcome of an investigation.

The GMC add that they have recently implemented changes/improvements during their ongoing ‘witness experience review’, including a tool to guide their staff which encourages them to carry out ‘an early assessment of each witness’s needs with signposting to our independent Witness Support Service where the witness is vulnerable or has emotional support needs’ amongst other things. They also say they have ‘recently introduced a process to communicate with family, next of kin or those close to the care of a patient where we are investigating concerns about the care of a patient who would otherwise lack a voice in our process because they have died, lack capacity or are underage.’ The GMC say they have worked with MPTS to ensure regular updates to witnesses and to improve the witness facilities at MPTS. They say they plan to introduce a feedback mechanism for witnesses by the end of the year.

Good practice examples:

- **family support from pathology services in sudden infant death seems to work well**
- **in cancer care we provide key workers for contact and advice. This could be mirrored for fatal incidents. As they are rare you would only need perhaps one such person across an STP but they could be independent of the investigation but having clear understandings of the process and procedure they would be able to support the family. They could even help the family in articulating concerns and grievances so they can be addressed by the investigating team.**

- The Royal College of Obstetrics and Gynaecology – ‘Trust Patient Safety Teams and non-involved senior clinicians are often allocated to support families during any investigation and communicate with them about the outcome of the investigation. Whilst these relationships are crucial to maintaining openness and trust between the hospital and families, the RCOG Women’s Network has expressed that they would like to see families supported further with signposting to other services that can support them, for instance counselling services and relevant charities. Trusts and health boards should work together with charities to be able to coordinate and signpost patients to appropriate, high quality support.’

- Healthcare Inspectorate Scotland – ‘Adverse Events team at HIS encompasses the Suicide Review and Learning System, which was created to help boards learn from suicides... When a suicide takes place NHS boards need to understand what happened and learn from any lessons identified. The lessons learnt are important to improve services and help staff recognise where risk exists. Suicide reviews are the way that NHS boards, and their mental health services, analyse what
happened and recognise where anything can be done to make things safer for other people at risk. The SRLS have created a Community of Practice to provide staff with useful information in this resource, including guidance or tools to assist staff through the review process. Guidance on the process of suicide reviews can be found Learning and Development section and includes a section on communication and provides guidance to staff on supporting families following a suicide.’

Issues noted in relation to patient support, in addition to the overarching involvement of patients within the investigation discussed under question 11, included:

- Doctors Association UK – ‘is aware that guidance about the provision of bereavement support exists currently. This, we feel, is not specific enough to ensure that healthcare providers prioritise the support of families during the investigation process. The process of contacting families, the allocation of family liaison officers, the disclosure of information and the level of contact throughout the entire investigation are not clearly defined. As a result of this, support for families is variable across the country with pockets of good practice and areas of poor. More work therefore must be done to strengthen this process, as we feel that appropriate support of families during this time will not only help with their bereavement but will also help towards achieving a no blame learning culture across the national health service.’

- The Medical Schools Council – ‘There is a lack of a standard approach to the provision of appropriate communication, support and information to families. An equivalent team to that provided in response to complaints could be considered. It could be helpful to define national minimum standards, subject to quality review for this area.’

Patient or family member comments on the support available indicate that generally they received no support. One specifically commented on the lack of bereavement counselling offered.

Another family member who reported receiving support specifically mentions that the benefits of a single point of contact:

- ‘We have been kept updated by phone, in person and email, we have been offered counselling, we had a personal contact who we could contact by phone mobile or email. Our personal contact has been extremely attentive and has at times gone above and beyond to help us with queries.’
Processes leading up to a criminal investigation

Question 15. How can we make sure that lessons are learned from investigations following serious clinical incidents?

There were 587 responses to this question online.

The majority of medical professional respondents highlighted the complexities of the multifactorial causes of errors, (eg system pressures and human factors) and the impact on a doctor’s actions as an area which causes them significant concern. They say that it is unfair and not appropriate for an expert/the police/the CPS/the jury/the judge to judge their performance with hindsight in abstract, with a perceived lack of understanding of the realities of the context in which doctors work.

Patients and family member feedback suggested a lack of confidence that lessons were being learned, including specific examples to support this perception. Their feedback indicated that they felt the independence of investigations and greater transparency of investigations within Trusts would help to foster improved learning. This view was shared by the Patients Association who told us that ‘...Patients want to know who is accountable for ensuring that lessons will be learned and for any changes to be made. Generally patients are not clear about where accountability lies, and the role of Trust Boards is not made clear. The governance arrangements for serious untoward incidents and complaints are not clear and transparent to patients and their families. Patients often find it hard to know what is going to change as a result of the harm to, or death of, their loved one...Some families would welcome the opportunity to share their story with staff and with wider stakeholders to be part of ensuring lessons are learned.’

An example of poor practice (in terms of lessons learned) shared by a patient, below:

‘Individual trusts are very good at making changes to prevent future errors within their own trust. However there is a serious lack of information sharing regarding catastrophic events between trusts. In 2016 a child was killed in a [named] trust, in 2017 my son was killed in a [another named] trust in a nearly identical way. Not only have two children now died but three doctors are now responsible for those deaths. Learning and sharing from one catastrophic event should be learnt in every single trust, countless lives will be saved...This needs to be mandatory practice for all trusts...We also find that in our case a drug safety alert issued three months before our son died was not adequately acted upon more needs to be done to ensure maximum compliance such as auditing to check the quality of risk assessments completed after receiving a drug alert...The head of pharmacy was responsible for acting upon the drug alert we feel that this was inappropriate given the intensive and time consuming responsibilities involved in running a department, staff and budget. We feel that patient safety is important enough to have dedicated patient safety staff in every trust, who's main responsibility is ensure that nationwide learning from siri events are implemented in their trust, completing adequate risk assessments and working with senior department managers to ensure risks are flagged and safety changes are made when a drug alert or siri is received. Following any serious adverse event resulting in death or long lasting injury, penalties should be considered for any trust found to have failed to take
adequate steps to implement safety changes after receiving a drug safety alert or siri from another trust, as they are in other areas such as tissue viability.’

**The role of the doctor to ensure lessons are learned**

We are reminded by the GMC that doctors are expected (as part of their professional duties in Good Medical Practice) to ‘contribute to and comply with systems to protect patients, including responding constructively to the outcomes of reviews and regularly reflecting on the standards of care they provide.’ They say they provide further guidance in this regard Leadership and management for all doctors. They also describe the role of revalidation in making sure that lessons are learned from investigations following serious clinical incidents:

‘Medical revalidation is based on doctors’ collection of supporting information from across their practice, and their reflection and discussion on it at regular appraisals… [which] allow doctors to reflect on whether the changes they have made have improved their practice, or whether they should take further action to make changes… Of particular relevance is the requirement to collect evidence about what we term ‘significant events’, and participation in quality improvement activities. At every appraisal, doctors must discuss and reflect on evidence of ‘significant events’ from their whole practice. Our guidance defines these as ‘any unintended or unexpected event, which could or did lead to harm of one or more patients…’ Doctors will be able to identify any patterns in the types of significant events recorded about their practice, and consider what further learning and development actions they have implemented, or plan to implement, to prevent such events happening again… Doctors must also participate in quality improvement activities at least once in their revalidation cycle, and again, collect, reflect on and discuss these at their appraisals.’

The GMC also stress ‘the critical responsibilities that employers/healthcare providers have in providing workplaces that enable learning where things go wrong or that may drive unfairness in cohorts of doctors most at risk.’

**Barriers to ensuring lessons are learned**

A number of respondents highlight the issues/barriers to the effectiveness of current processes for ensuring that lessons are learned from serious incident investigations and point to the role of HSIB and other initiatives which will/ought to improve the situation.

**Blame culture**

There was a broadly shared view that the blame culture/prevailing fear of criminalising mistakes is detrimental to learning, as it deters doctors from reporting errors and/or reflecting openly on mistakes. The word ‘blame’ was used in the online responses to this question, 130 times. ‘Culture’, 129 times. ‘Fear’ 37 times.

One medical professional says ‘…we are not learning. We have a system often driven by fear of reprisal. I run a “learning from events meeting” for near misses. I was told by 2 Consultants not to start it as we "shouldn't air our dirty linen in public" - this is fear.’

Many respondents (doctors and organisations) felt there was a need for a shift from focussing on apportioning blame or culpability to a ‘no fault/no blame culture’ and to provide protection for healthcare workers, in order to ensure that lessons are learned. We
are told that ‘...A culture of prompt and full disclosure of mistakes needs to be fostered, with praise and credit being given for doing so. There is a need for senior clinical leadership in this, with an end to the leaving of junior members of staff to deal with difficult situations.’

Health Education England suggested a model which might help – ‘The model for investigation of deaths for those with learning disabilities should be followed for all deaths. In other words the family should be involved but it should be clear that the investigation does not aim to apportion blame rather it is looking to prevent harm to future patients.’

Some say that this culture shift needs to be facilitated at ‘department level’ and they should be responsible for disseminating lessons learned too. Respondents (including for example the Royal College of Pathologists) say that ‘...focusing on culpability does not serve patients; their families, friends or carers; the general public; doctors; nor the NHS.’ The Royal College of Radiologists add that ‘...On an individual level, those who have made an error need to be able to reflect and be supported to change their behaviours/access extra training as required.’

NHS Education for Scotland NES highlight that ‘...various high-profile inquiries and reviews have consistently identified similar themes, including the need for a standardised investigation process and a change in culture whereby staff feel they can report mistakes and adverse incidents without fear of retribution...However, it is clear that, despite long-standing calls for an open learning culture in the NHS, barriers remain. It is important that there is sharing the results of investigation widely – to the whole clinical team, across directorates and departments at a local level and via regional and national fora including across and between NHS Boards, with Colleges / Specialty Associations. This needs to be done in a no blame culture emphasising learning and development. Review of change of practice and audit of this should be documented.’

There were many references to the airline industry and learning from this, for example one respondent says that ‘...We should take an example from the airline industry where individual submissions to SUIs and their conclusions are not admissible as part of a criminal process’

Linked to the above (the impact of a blame–culture), there were suggestions that introducing some kind of no-fault compensation scheme could improve openness and transparency, and help ensure lessons are learned. The Royal College of Emergency Medicine flagged the report of the No-fault Compensation Review Group in Scotland in 2011. ‘Although the Scottish Government expressed reservations about these proposals, citing the ‘costs and the complexities involved if such a scheme was to be introduced,’ the Royal College of Emergency Medicine takes the view that these proposals, or others like them, should be re-examined. This approach would mean a less adversarial system and move the focus away from the individual clinician and more towards the environment in which they practice medicine.'
Poor dissemination of learning

Many respondents suggest that there is poor dissemination of learning following patient safety or other investigations where lessons should be learned. Others highlight the issues with ensuring the outcomes are disseminated to all involved in a timely manner. For example the Royal College of Pathologists advise that ‘...Investigation reports tend not to be circulated for comment or discussed widely enough to allow true learning. There is a natural desire to keep secret errors and misjudgements but this impedes learning. It is also not clear how and when action plans are followed up.’ Others say that the current root cause analysis or serious untoward incident processes ‘seem to prevent any immediate discussion of the incident within the department,’ and some argue that ‘reports seem to get lost in the systems and trainees especially may have moved on before any issues or updates are implemented... so the lessons will be lost to them.’

Some respondents called for the ‘application of duty of candour to senior healthcare leaders’, and that ‘outcomes from SUIs should be demonstrably enforceable, that audit mechanisms should be introduced ‘to close the loop and provide evidence that lessons have been learned,’ and a body should ‘give advice that is binding, both by CEO and clinicians nationally,’ which should also be audited. The Doctors Association UK add that ‘...The lessons learned as part of an investigation should not be kept private or hidden away. Each trust should be required to publicly publish their findings and action plans. This would help to ensure that there is a nationwide step change in looking to learn from the experience of other healthcare providers across the NHS.’

Another respondent tells us that, ‘there is too much variation, for example there should be a national searchable database of all regulation 28s from Coroners inquests reports. They say they ‘...have reported back as an expert on regulation 28 cases and know of instances where the regulation 28 outcome is not in the public domain some years later.’

NHS Education for Scotland (NES) advise that ‘...Investigations are often process-driven and acute sector organisations often see the formal investigation process as the only available option for learning from incidents resulting in harm. In some cases, an alternative approach would be more beneficial, using less complex but more efficient ways to address the needs of the patient’s family and identify any mitigating actions that could prevent the incidents happening again.’

The Royal College of General Practitioners highlight that ‘...there is currently a gap between England and the Devolved Nations in relation to the ways in which doctors can raise

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9 ‘reports to prevent future deaths’ Paragraph 7 of Schedule 5, Coroners and Justice Act 2009, provides coroners with the duty to make reports to a person, organisation, local authority or government department or agency where the coroner believes that action should be taken to prevent future deaths - Details of the procedures are set out in Regulations 28 and 29, Coroners (Investigations) Regulations 2013, (these were formerly known as Rule 43 reports).

10 The website (https://www.judiciary.uk/related-offices-and-bodies/office-chief-coroner/pfd-reports/) says that, ‘the Chief Coroner’s Office is currently working to upload all Reports made since 25 July 2013.’
concerns. In Wales, there is no equivalent mechanism to exception reporting for junior doctors and the Guardians of Safe Working. In Northern Ireland and Wales, there is currently no statutory duty of candour at an institutional level; however, on 17 June 2018 the First Minister of Wales announced a new legislative programme which brings forward a bill to establish a statutory duty of candour on all health organisations in Wales, and in Northern Ireland, the recently published Inquiry into Hyponatraemia-related Deaths report calls for a statutory duty of candour in Northern Ireland as one of its 96 recommendations. A new independent body will also be created in Wales to give people a stronger voice for their experiences of health and social care services. The College supports consistency in reporting mechanisms across the UK. We suggest exception reporting is standardised and extended to encompass all doctors, across the UK.

**Calls for a national body/human factors assessments/ ways to ensure thematic learning**

A number of respondents recommend a national body to review learning and to find common factors. They say there should be central reporting and closer monitoring in order to identify similar events, and a centralised accessible system/database for accessing and sharing learning. This would particularly assist in the issue that institutional learning/organisational memory is seen to be poor.

They advocate for ‘making it only one organisation’s job to oversee the outcome. As currently the trust, CCG, CQC, NHSI, Ombudsman, coroner, civil courts, GMC/NMC, local government health committee, deanery, etc all get involved.’ One respondent suggests that this should be ‘a national body such as the HSSIB that uses Human Factors and Systems thinking to look at areas and then feedback to all health boards.’

One patient or family member told us that they were... ‘an elected Governor at a local hospital for 6 years and attended the hospitals “Learning from Incidents and Risks committee”’. They say that they ‘found the standard of investigation poor and the measures put in place to prevent recurrence weak. For example, following a medication error the preventative action would invariably be to suspend the nurse involved until retrained. This did nothing to prevent the thousands of other nurses in the Trust from making similar mistakes. And they did. Several hundred times a year. Staff carrying out investigations, need much better training to include Human Factors and While System Safety. They also need much more time to carry out investigations and to develop improved systems of work.’

A number of respondents similarly suggest that what is required is the ‘...Involvement of external assessors with proper training (sympathetic to all sides, trained in mediation, human factors, system factors, black box thinking). ...Using degree and above qualified human factors investigators to make reports.’

The Medical Schools Council agree that there is an issue with regards to serious incident reviews missing systemic/human factors analyses, saying that they ‘...are often undertaken by individuals who determine whether or not the management was consistent with guidelines. The recommendations made from such investigations often do not consider the bigger picture and the effects on other aspects such as the implications for finance or
training. Conventional risk management processes address learning from serious and ‘near misses’. However, these commonly focus on identifying clinical decisions that could have resulted in an alternative outcome, rather than identifying system-derived factors e.g. staffing, filing of results, computerised processes. Systematic analysis of all contributory factors is needed, clinical and non-clinical.’

Similarly another respondent suggests ‘...National learning from local critical incidents and complications is vital if improvements in national patient safety are to be made. This may require a ‘safe reporting area,’ as used in the Royal College of Anaesthetists National Audit Projects and proposed by the HSIB.’

In fact, many organisations indicated support for the future role of HSIB, the implementation of the draft bill and the provision of ‘safe space’:

- The Academy of Medical Royal Colleges say that they hope HSIB is resourced sufficiently to ensure it can carry out investigations which lead to improved learning and also help develop spread expertise in incident investigation.’
- The GMC supports ‘the establishment of a Health Service Safety Investigations Branch in England on a statutory basis and the proposed ‘safe space’ approach to investigations.’ They say ‘It reflects the aim of our 2018-2020 Corporate Strategy to move regulation upstream, to promote a learning culture which identifies and addresses risks at the earliest possible point and to help prevent avoidable harm from occurring in the future. It is also consistent with our guidance to doctors about their responsibilities to learn from mistakes and reflect on their practice, and their duty to take part in systems of quality assurance and quality improvement to promote patient safety.’
- ‘The BMA is supportive of the implementation of the Draft Health Service Safety Investigations Bill (DHSSIB) and its intention to promote system wide learning to reduce and prevent similar adverse patient safety instances occurring in the future. We believe if established, in line with the suggested improvements made by the DHSSIB Joint Committee in its report, the body can act as a valuable tool to achieve these aims.’
- The NMC agree HSIB provides a welcome step forward here, ‘although it should be recognised that its reach will be limited given that it only envisages conducting up to 30 investigations a year and is confined to England alone.’
- RCGP – ‘The HSSIB is intended to operate within England, however we understand the devolved administrations were engaged in the drafting of the Bill’

One respondent suggests that ‘by keeping a national anonymised register of such incidents with open access to all’ would to ensure that lessons are learned following serious clinical incidents. They say that ‘...Such a register could be itemised into clinical specialty for ease of referencing.’

A number of respondents said that there is a long history of ‘good practice’ in the NHS of promoting confidential and/or anonymised reporting, whereby lessons should be written up in anonymised ways and shared with health care professionals, for example ‘...in the way that MPS and MDU share case studies with their members.’ Or the following former/current initiatives: the Confidential Enquiries into Maternal Death, National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and the Royal College of Anaesthetists’ (RCoA) National Audit Projects.
We are told (by DAS) that this reporting has created registries of untoward events, enabling analysis which has led to national recommendations, leading to marked improvements in safety and quality of delivered care. For example, a study investigating the impact of NAP4, a RCoA/DAS national audit of airway complications, reported that 97% of UK hospitals had changed their practice and had implemented recommendations of this study.

There are a number of calls for a drawing together and sharing of themes following fatal incidents at a national level... rather like the national Inquiry into homicide and suicide. Such themes should be circulated as a report that can be presented within Trusts and services’

One respondent recommends that ‘...The health system needs to look at how the HSE [the Health and Safety Executive] deal with deaths, how they investigate and prosecute and produce a report which can be used to train others to avoid further deaths’

Another respondent highlights an initiative in anaesthesia whereby ‘...The RCOA release a quarterly patient safety update which is circulated to all college members. It aims to spread the lessons learnt from incidents.’

The Faculty of Pharmaceutical Physicians, shared details of practice in their area with regards to the reporting of deaths following ‘mistakes’ in such a way that the resulting database can be used to guide change in medical practice. They say that ‘A report should be made both locally and submitted to the National Reporting and Learning System (NRSL). This organisation can issue an alert that goes to all NHS providers with new guidance to avoid and prevent risks, so providing learning to all who work within the NHS...Involvement of patients (and relatives) along with healthcare professionals for reporting on serious clinical events and unexpected deaths to the GMC could be a valuable development. Alignment with medicines reporting and medical provision could be considered an example on which the NHS could model its reporting and provision of training.’

Healthcare Improvement Scotland tell us about ‘...The Adverse Events Community of Practice website11 which has been set up to support NHS boards to share learning for improvement following adverse events reviews. The aim is to widen the scope to sharing learning from other patient safety sources, such as complaints and claims, across both health and social care. NHS boards use the learning summary template to share learning about: service improvements following recommendations and actions that have come from reviews with potential national application improvements in the management of adverse events e.g. in relation to the process of reporting, reviewing and learning from adverse events, and risk awareness notices.’ They also add that they have ‘...agreed with the Procurator Fiscal to share the learning points from particular reviews into deaths more widely across NHS Scotland12, in order to facilitate national learning and improvement. The aim of this process is to ensure that learning from death investigations is shared in the most

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11 Published learning summaries and further guidance and information can be found here: http://www.knowledge.scot.nhs.uk/adverse-events/sharing-learning.aspx.
12 http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4089731/0d5b7acc-189f-410f-96c9-3cb6cde4a444.pdf'
efficient and effective way possible, and ensuring that this is done in collaboration with the NHS board in which the review took place.’

A number of individuals and organisations, including the Royal College of Physicians and Surgeons Glasgow, recommend that ‘...Processes are also needed that allow for collation and review of multiple low-level concerns and for sharing information about matters learned at trust or board level. This will require appropriate resourcing of clinical governance and clinical risk by Trusts and boards.’ Similarly, Difficult Airway Society (DAS) Human Factors and Ergonomics (HF/E) group say that ‘...Learning from events that do not go to plan – as well as those that do – is a key part of improving safety in healthcare and has been a cornerstone of improvements in healthcare.’ Others add that ‘near miss’ learning events should be discussed at regular intervals in a learning environment where change can be brought about. Some go so far as to say that learning from lower level concerns, near misses and from identified good practice ‘works better’ than investigating significant/serious events.

The BMA say that ‘...Team debrief following serious clinical incidents, such as using Schwartz Rounds for departmental learning and support of staff must be implemented regularly to ensure lessons are learned.’ They add that ‘...It would be useful to use scenarios based on past incidents as training exercises within Healthcare Organisations, and also as training for medical students.’ Similarly others recommend that morbidity and mortality meetings should be used and that healthcare organisations should ...‘disseminate the findings widely in trainee teaching sessions. Use the situation as a case discussion.’

Suggestions for improving serious incident reporting and investigation included:

- ‘it should be made possible to report incidents QUICKLY AND WITHOUT FUSS... a one page form which takes only seconds to complete, which is then collated into a database and cross referenced with other similar events. ..Any new reporting and dissemination systems must be tested for speed, or, to put it another way, one should quantify how much time they steal from the next patient.’
- ‘Give sufficient resources for investigations and learning, non-clinical time set aside to discuss incidents and time for reflection.’
- ‘need the investigation to be conducted by credible clinicians and the report has to be credible. as often as not it will be about resources and systems and managers have to accept this is central not peripheral to clinical errors.’
- ‘By asking investigators to make recommendations that are feasible to implement.’

- Learning reports must be short so that they are read and digested.

- A few individuals suggested to incentivise demonstrated learning from incidents, saying for example ‘...we should have more positive reporting to boost the desire to perform well and improve morale.’

- A few calls to involve patient/lay reps in learning meetings to ensure accountability.

- A few respondents highlighted the need for better emotional support for doctors, as this would support their learning and so that ‘they are strong enough to be able to accept their mistake.’
Independent review of gross negligence manslaughter and culpable homicide
Question 16. Do you think that the current arrangements for reporting and investigating serious clinical incidents within healthcare settings are effective and fair? If not, what is wrong and how might they be improved?

There were 577 responses to this question online.

Overwhelmingly responses indicated that the current arrangements are not felt to be effective and/or fair. There were a number of themes identified in the question before this one that were reflected again here. In particular, the barriers to, or issues with, processes that prevented lessons being learned following a serious clinical incident investigation.

Patients and family member feedback

- Interviews required because of catastrophic error should be carried out by wholly impartial professional bodies such as the police, the GMC or trained impartial mediators, not by hospital staff. The interview was not recorded accurately there were large gaps in the interview and the tape recording was deleted.

- We were treated with contempt! Needs to be complete honesty from the outset. All that is needed is transparency. Honesty. People who do not care are careless.

- Again in my case absolutely not. It is not fair because I have the perception that the trusts and medics reputations must be protected at any cost so fair investigation is impossible. CCTV cameras everywhere particularly in ITU and family EOL withdrawals from ventilators conversations recorded and witnessed. Cameras can record some of the truth.

- One respondent left the following comment in response to another question but it is perhaps more relevant here ... ‘Being a bereaved parent and an employee of the trust that failed my child is difficult. Even now we have requested information through FOI [freedom of information Act request] but it is being withheld from us.’

Medical professionals, representative and membership organisations, MDOs and trade unions

A few people suggested there is over-reporting (eg of things that don't require it), however more respondents suggested that in fact there is under-reporting of incidents. They cited as reasons for this:

- the fear of loss of job/career/earnings (with the word ‘fear’ being used 39 times in online responses to this question)

- lack of feedback on the incidents that are reported, which we are told, acts as a disincentive to reporting further issues

- ‘an incentive to ‘down grade’ incidents due to ongoing blame culture’ (with the word ‘blame’ being used 132 times in online responses to this question, and ‘culture’ 81 times)

- lack of reporting and investigation of serious ‘near miss’ incidents.
Reasons given as to why current arrangements are not thought to be effective and/or fair included, institutional bias and over-representation of black, minority and ethnic doctors (BME doctors) in investigations. The GMC tell us that they have commissioned a further detailed research project (building on findings of a Community Research report), to be led by Roger Kline and Dr Doyin Atewologun. This ...is to better understand why some doctors are referred to us for fitness to practise issues more than others and to understand the factors that influence the referral of doctors into GMC fitness to practise processes by employers/healthcare providers. This research is intended to identify ways in which the GMC, clinical leaders, and management can work together to help develop workplaces in which doctors’ interactions with the GMC and local processes are fair. The ultimate aim of this research is to increase understanding about the pattern of referrals to the GMC of different groups of doctors, and to increase assurance about the systems for and the approach to referrals of such groups.’

The Medical Schools Council say that ‘...Protocols and training should be regularised nationally, including QA with fairness and impartiality for black, minority and ethnic doctors.’

There were a number of other reasons given by respondents as to why the current arrangements are not effective or fair:

A recurrent theme identified again in responses to this question is that the investigation processes are variable and inconsistent between departments and healthcare providers.

NHS Improvement advises that ‘A separate consultation which covers elements of this question is already underway.’ They give the view that ‘investigations are in general fair’; however, they also ‘accept that they can be ineffective and hampered by procedural standards that demand resources be applied to mandatorily investigating incidents that occur as a result of known problems that are being actively remediated, and arbitrary time limits and other standards that can, on occasion limit the ability of an investigation to fully evaluate a complex system.’ They also accept that ‘there is variation across healthcare organisations and this may benefit from more detailed national guidance.’

Similarly, the Royal College of Obstetrics and Gynaecology say it is ‘concerned about the lack of consistency in the processes for reporting and investigation of serious clinical incidents at a local level. This lack of consistency also results in doctors being unclear about the processes for investigation, and when an investigation might escalate further.’ Doctors Association UK add that ‘...there is also uncertainty about reporting processes. The majority of healthcare providers use electronic reporting forms; however, concerns can also be reported verbally or in writing to supervisors. Doctors in training in England may also report immediate safety concerns as part of their exception reporting process. It is important that healthcare providers have a means of capturing all these concerns so that they can be investigated and recommendations to improve patient safety made.’

Unlike the majority of respondents who identified inconsistencies and a lack of effective frameworks, Healthcare Improvement Scotland say that ‘...The national approach to learning from adverse events provides a clear, consistent governance framework for reporting, managing and reviewing adverse events.’
As we have seen from the themes identified in many of the responses to the questions before this one, there is a strong perception about the prevailing blame culture in healthcare and how serious incident investigation processes are being used to blame individuals. For example one respondent tells us that '...there is a sense of dread from reporting an incident that blame will be delivered by those who were a) not there at the time and b) would not ever have been in the same position of personal risk (ie having to take clinical decisions. So a process of investigation need to be supportive and delivered (or at least have input) by those who are in similar situations having to take difficult management decisions that involve risk.'

The Medical Defence Union add that '...In some cases it seems as if a decision has been taken from the start that a particular individual is 'to blame' and the investigation proceeds on that basis in order to provide 'proof', rather than starting with a clean sheet and an attempt to ascertain the facts before reaching any judgement.' Royal College of Physicians and Surgeons Glasgow tell us that '...Current processes are often not perceived as fair. Morbidity and mortality meetings at department level can be handled supportively, but more formal risk management processes are often perceived as operating within a blame culture.'

Some respondents highlight particular concern for the vulnerability of junior doctors - particularly threats to their future career if they speak up/raise concerns. One medical professional tells us that they '...have been told twice as a junior doctor not to rock the boat or I would risk not getting a job in the future.'

A couple of other respondents commented that the inputting of incident reports is used a as threat by colleagues. Along a similar thread, the Royal College of Pathologists say that '...Serious incidents can be used to victimise certain employees. Whistle-blowers are often held to higher standards than other employees.' A number of respondents told us that there are challenges for whistleblowers/those raising concerns.

Another recurrent theme that we have seen in responses to previous questions, is the failure of investigations to take into account systemic issues and the processes not identifying the right information from which to learn. The question should be ...‘what changes do we need to make to the system and support structure, not let’s get rid of the person and keep the same system and support structure. Please refer to Matthew Syed publication 'Black Box thinking'.’ Another respondent advises that ‘...In Clinical Risk Management the starting assumption is that all parties are well-motivated and that poor systems, not poor individual performances, are the usual cause of error or mishap. Another tenet is that the individuals involved in a particular incident are so traumatised by being involved, that they are already among the people least likely to repeat the error, and that therefore corrective actions, be they educative or punitive, are not required for them. The prosecution service and the GMC would do well to emulate this starting assumption (with the proviso that they can revert to draconianism if it turns out to be required).’

We are frequently told that there is a lack of outcomes and feedback being shared, and there is a lack of learning between different specialties and different departments. We are told that you ‘never receive an outcome as the individual who reported them or might have
been involved.’ Never hearing back from reporting serves as a disincentive to report again, or ‘reporting things and not hearing back for two or three years and then in an over formal setting means that there is no real learning that happens.’

- Junior Doctors are often not involved in the clinical incident investigation, are not fairly supported throughout the process and are not given the opportunity to comment on any serious clinical incidents - but members of "permanent staff" i.e. consultants are given such access.

We are told that serious incident investigations are not effective because healthcare providers fail to learn or to implement learning identified in them- the same incidents reoccur frequently. For example MENCAP tell us that ‘...Recurrent themes in the poor care of people with a learning disability include diagnostic overshadowing, failure to provide basic care, failure to make reasonable adjustments and failure to involve families. Many of the families that come to us, recount situations involving serious failures on the part of doctors that they believe have contributed to the death of people with a learning disability. However, during investigations, the themes that we believe led to the death of the person with a learning disability – including the diagnostic overshadowing, fundamental lack of understanding of learning disability and how to adjust care, do not seem to be adequately addressed in the internal investigations process, leading families to seek the Ombudsman’s involvement, as well as seeking an inquest. ’

NHS Providers say that ‘...the persistence of never-events and other common patient safety harms implies that significant time involved for trusts in complying with current SI reporting, review and mortality processes may be disproportionate to and insufficiently insightful to the learning opportunities presented. As such these processes require reconsideration and elimination where possible, particularly if new (more effective) processes are to be introduced.’

We also heard here again about the issue of the perceived multiplicity of routes for complaints and multiple organisations carrying out investigations into the same incidents (multiple-jeopardy) potentially at the same time as the local investigation or the local investigation not being completed until after all other proceedings. We heard from one respondent about their experience:

‘After 7 months of being off work there was a very efficient and sensible local investigation. This is done after the police investigation and after much of the harm to the doctor has been done. If this had preceded the police enquiry or even calling the police, then not only would the doctor be saved the horrors of the time out but vast costs would be saved too. The fact is that when a patient dies it creates a scenario of police, GMC then local investigation. However on ICU where up to 30% of patients die this becomes a huge burden for any doctor working in intensive care. The medical director for the hospital has the power to have the local investigation before calling the police. I know that many medical directors would have done this. Therefore it is left to individual doctors. This is a weakness in the system and open to personal prejudice.’

Many respondents also describe how the serious investigation process is too slow in producing outcomes. For example, Health Education England say that investigations take
too long and add that ‘the reports are directed at boards not families.’ A number of respondents argued that the reporting process is ‘too burdensome’, ‘filling out of forms too wordy/cumbersome’ and that Datix is not fit for purpose and ‘nothing seems to change.’ Datix (we are told) is: over-used and laborious/difficult to fill out. They say that ‘front line staff are overworked, and taking the time to report incidents has to be balanced against the harm resulting from the loss of front line staff for the time it takes to report (usually around 20-30 minutes additional to regular duties).’ Similarly, the Care Quality Commission shares ‘...feedback from provider organisations that it is not always straightforward to report serious incidents as the IT to do so is difficult to use, it takes a long time and rarely offers feedback to those who complete it. The consequence of this is there is little incentive to report in a timely and effective fashion... CQC feels that more effective feedback loops and a shorter set of questions would help this situation. CQC believes that in other industries the questionnaire after an incident is short and succinct.’ Individual respondents also suggest there should be a quick way to record an incident as it occurs, and an opportunity to return to discuss/ add detail later, when there is more time.

The Medical Defence Union say that ‘...In some trusts not enough time is set aside for the investigators to take evidence from witnesses and participants and the process is rushed which can result in incomplete and/or inaccurate reports and misleading conclusions....need to set minimum levels of resource for investigation teams and minimum levels of knowledge, skills and experience for the investigators themselves.’

Others add that there is also not enough resource (staffing and finance) to implement the required improvements identified in the investigation.

A medical professional shares their experience, saying that they ‘...have been part of an investigation of a serious clinical incident. When I asked to meet with the lead doctor who criticised my care I was told by the complaints manager who was co-ordinating the trust response that this would not be possible, as it may be thought to be influencing the outcome of an external report which was also being conducted at the time. Therefore there was no opportunity for lessons to be learned and it took around 9 months before the external report was issued.’

Other issues identified included:

- The RCOG ‘has concerns about the grounds under which a trust may initiate an investigation for Gross Negligence Manslaughter. Greater clarity is required about the role of the Serious Incident (SI) process, in light of the updated standards and the proposed bespoke SI framework for maternity care. It is important that those processes are informed by this findings from this review.’
- ‘The people involved in the process are not necessarily trained to manage people and their fears for their career and income.’ Another argues that ‘Investigators are prone to place their perception of maintenance of public confidence above their duty of candour.’
- ‘It is not fair that these [serious incident] reports are admissible as evidence in legal proceedings.’
- ‘Organisations investigating are too concerned and give too much attention to media reports or perception.’
• BMA say that ‘...Whilst the clinicians investigating a serious untoward incident are given significant rein as to the questions that they ask and investigation they pursue, we have been informed by some members that there can be a great degree of interference by the management of the healthcare organisation.’
• MDU add that ‘...It is not always a given that the doctor under scrutiny has the opportunity to provide full evidence and too many doctors aren’t aware of criticisms that are made of them or given an opportunity to comment before such criticisms are included in the final report. Sometimes doctors don’t see the investigation report until after it is finalised, even if such a report is passed to the police.'
• More clarity is needed about how to decide what to report and the level of investigation needed together with the ability to quickly step up or step down as the facts emerge.

Suggestions for ways to improve the situation:

In terms of moving away from a culture of blame to one of learning or a just culture, the BMA ‘...fully support the recommendations in Sir Robert Francis report into the failings at Mid-Staffordshire that there should be appointed both a national Guardian as well as local Guardians in all Trusts. These would be appointed by the Chief Executive, would be genuinely independent and have responsibility for promoting a culture of safety and speaking up in NHS Trusts. The Freedom to Speak Up Guardian would act as an independent and impartial source of advice to staff at any stage of raising a concern, with access to anyone in the organisation, including the chief executive, or if necessary, outside the organisation.’

Some individual medical professionals say that the system needs to radically alter to a full no blame investigation – ‘rather like CEPOD\textsuperscript{13}'. A suggestion for a way to move towards that is to ‘remove wording from such investigations that has connotations of blame and wrongdoing, such as ‘wrong' and ‘mistake', and replace them with 'differently next time', for example.’ Others recommend anonymous reporting systems.

The Royal College of Anaesthetists are ‘...encouraged by the publication of A just culture guide by NHS Improvement, containing a series of steps to help NHS staff conduct an honest conversation between managers and individuals involved in patient safety incidents through the application of a ‘deliberate harm test’. The guide is not a replacement for an investigation, but we would encourage the review panel to explore how it can be used in the initial local investigative processes to ensure that staff involved in safety incidents are treated fairly and with compassion.’ NHS Improvement tell us that ‘...the Learning from Deaths guidance needs further implementation and step by step guidance for trusts. Duty of candour is essential!’ MDU also highlight NHS England Quality Board guidance on learning from deaths which ‘advises that clinicians needs to be trained and supported to help them to communicate with families and friends, which is of course important, but there is no mention that clinicians themselves may need support, or that they should be able to

\textsuperscript{13} The National 'Confidential Enquiry into Peri-operative Deaths' website here https://www.ncepod.org.uk/
look to their employing trust to give them such support. It is interesting that, in contrast to this approach, the new Duty of Candour Procedure (Scotland) Regulations 2018 require (Regulation 8) trusts to provide staff with details of support available to them. This is a step in the right direction.'

A number of respondents called for a definition of what constitutes a 'serious clinical incident' and that the findings of investigations should be made available to all who might make the same serious error. The Royal College of Pathologists say ‘...The rules and definitions of serious incidents are highly open to interpretation. More emphasis on what went well would place mistakes/deliberate deviations from good practice in context. A fundamental restructuring of how investigations are done with a requirement to report good care and good practice and how to ensure this is repeated rather than a process that ends up as a list solely of what went wrong and how to prevent recurrence.’

Others say that the healthcare systems need a 'set framework and independent oversight of investigations.' For example, James Titcombe advises that the processes will improve with standardisation. He recommends a charter for the investigation of health professionals, training for those involved, monitoring of cases (numbers, types, racial / ethnic mix) - numbers reported, time to completion, outcome (judgement), and satisfaction of participants.

In terms of ensuring that the learning has been shared and implemented we are told that ‘the acknowledgement of a receipt and comprehension of the advice given should be mandatory, either by attendance at a meeting specifically for the purpose of imparting the information about the incident and the advice on how to avoid it or by checking that all relevant persons have read and understand the information.’

We are repeatedly told that investigations should be undertaken independently (eg not investigating your own colleagues). For example the Royal College of Pathologists advise that ‘independent and lay observers should be involved.’ Investigators also need appropriate expertise – investigations must involve clinical staff, with ' a working knowledge of the complexities of clinical medicine and a balanced understanding of the system within which the clinician is working.’ Many respondents call for the need to consider ‘swiss-cheese model’ saying human factors and/or root cause analysis necessary.’ Difficult Airway Society (DAS) Human Factors and Ergonomics (HF/E) group add that ‘...investigations are complex, and are best carried out by trained experts: this is commonplace in other safety-critical industries (a good example is aviation, where a visiting team investigates adverse events to learn from mistakes without apportioning blame), and is the principle behind the newly established Health Service Investigative Board (HSIB).In healthcare, such investigations are often carried out by individuals within the same organisation, with limited training and minimal or no HF/E expertise.’

Royal College of Psychiatrists Scotland advise that the processes for local investigations, and the variation of these investigations, are currently being reviewed by Professor Craig White...The remit of the ‘Learning from Loss’ consultation is specifically about mental health services.’ Therefore they advise that the Review ‘liaise with Professor Craig White, and
profit from the findings of the Scottish Government’s review into the experience of families and carers in cases where patients have died within the care of mental health services.’

NHS Scotland – tell us that the causes of risk and harm to patients are complex and multi-factorial. So they believe innovation is needed and say that they hope...‘the monitoring of an amber -zone of risk by using the concept of 'Insightful Practice' offers possibilities. Importantly, embracing a culture of amber -zone monitoring would open up a more exploratory dialogue and help promote a more and early in depth examination in cases where there are 'suspicions or any concern of criminality' father than waiting for serious harm to occur.’

NES suggest:

- prioritising serious incidents that require full investigation and developing alternative methods for managing and learning from other types of incident
- routinely involving patients and families in investigations
- engaging and supporting the staff involved in the incident and investigation process
- using skilled analysis to move the focus of investigation from the acts or omissions of staff, to identify the underlying causes of the incident
- using human factors principles to develop solutions that reduce the risk of the same incidents happening again.

RCOG stress that the role that leaders play is critical in ensuring a positive workplace culture. They say they have found huge variability in the ways in which local leaders (for example Clinical Directors and Medical Directors) manage complaints. The RCOG recommends that more work is done to standardise the quality of support and response to issues arising from complaints. Clinical Directors are not provided with any formal support and may not be experienced in managing complaints. Standardised training on dispute resolution would help with variation in managing complaints and conducting investigations.

NHS Improvement recommend that ‘...The outcome of an investigation in terms of learning should be associated with auditable standards at a local level, but should also be formatted in such a way that it allows aggregation and analysis at regional and national level. Some element of this exists for simple clinical incidents through the NRLS14, however variation in process and formatting of SI reports prevents aggregation of the learning from incidents, particularly as the investigation process becomes more complex.’ NHS England tell us that NHS Improvement are working to deliver a successor to the NRLS and the STEIS (Strategic Executive Information System) through the Development of the Patient Safety Incident Management System project. The project will develop a new system to better support the NHS to learn about what goes wrong in healthcare, and provide learning resources to support safety improvement.

Health Education England believe that ‘the learning disability death reviews are the way forward and should be applied to all deaths.’ Whereas, the Hospital Consultants &

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14 The National Reporting and Learning System (NRLS) is a central database of patient safety incident reports – website here [https://report.nrls.nhs.uk/nrlsreporting/](https://report.nrls.nhs.uk/nrlsreporting/).
Specialists Association believes that an external body with specialised training in serious clinical incident investigation would be better placed to yield meaningful findings which can be used to implement lasting systemic solutions. An appropriate model would be similar to the Rail, Marine and Air Accident Investigation Branches.

One medical professional highlights that ‘there is no ability to apply levers to those managers who do not understand clinical governance, and those executive teams who do not implement effective organisational governance. Therefore those managers should also be held to account in a more transparent way, or there needs to be a clear system of medical involvement in decision making, by Consultants who may not be part of organisational management structures.’
Question 17. Would there be benefits in ensuring a human factors assessment approach is used in local investigations as opposed to a root cause analysis? ‘Human factors’ refer to the environmental, organisational and job factors, and human and individual characteristics which influence behaviour at work in a way which can affect health and safety. A ‘root cause’ analysis is a systematic process for identifying ‘root causes’ of problems or events and an approach for responding to them.

There were 612 responses to this question online.

There was overwhelming support for a human factors approach/assessment in investigations. The word ‘absolutely’ was used 48 times in responses to this question. ‘Understanding’ (22 times) human factors is seen as ‘essential’ (25 times). Some highlight the current trend in the expansion of the use of HFA in the NHS. Although some respondents advise that there is a lack of progress or action in the adoption or implementation of HFA in healthcare. NHS Providers flag for example, that ‘the Clinical Human Factors Group has produced a lot of material to support the expansion of human factors approaches in the NHS’. However, they also say that the commitment in the NHS Human Factors in Healthcare Concordat (2013) ‘have not in most part been matched with action towards delivery’, with the exception of Health Education England incorporating human factors in patient safety education and training curricula.’

A number of respondents (including the BMA) point towards the Healthcare Safety Investigation Branch (HSIB) (HSSIB if/when the bill is implemented) which ‘will take a view when reporting as to the impact of multiple factors, which may include issues such as workforce (ie HFA).’ Healthcare Improvement Scotland advise that ‘…the 2019 review of the framework will increase emphasis on human factors/systems approach.’

A few respondents highlighted that if root cause analysis (RCA) was done ‘properly’ then human factors would be or are taken account of and that the two methods are by no means mutually exclusive. For example, MDDUS tell us that it is not their ‘experience that RCAs necessarily discount the so-called “human factors”; certainly, where systemic issues are identified, these can and should be addressed within a root cause analysis.’ Indeed, NHS Improvement tell us that ‘RCA explicitly supports analysis from a human factors perspective as a fundamental part of the identification and examination of contributory factors. The RCA contributory factors framework (launched by the NPSA in 2004 and updated in 2009 and 2012) was developed by a human factors specialist and includes the widest range of human factors taxonomy to drive the use of human factors assessment within good quality systems root cause analysis investigations promoted in the NHS since 2004.’

Many respondents indicated that there is and should be a role for both RCA and Human Factors approaches and that they are complementary to each other (that resources, organisational factors and culpability must also be taken into account). For example, NHS
Scotland say that ‘...Appreciation of both is important and is consistent with an approach based on mounting of professional practice using ‘Insightful Practice’.’

However, respondents also said that there is variable quality and inconsistency in the way RCA is carried out across the healthcare systems of the UK, meaning that human factors are not adequately assessed or at all. Or that ‘...both approaches will find multiple causes as with any accident - it’s just easier to focus on human errors than system and environmental causes as there is a lack of will, funding and staff to correct these.’ NHS Improvement advise that ‘...the RCA method is sometimes cited as the cause of investigation flaws, but review of such published critiques suggests problems with implementation rather than fundamental flaws in the RCA methodology.’ They add that ‘...One of the most common issues is disproportionate focus on some of the activities associated with the first two phases of the investigation process (that is, setting up the investigation and gathering information), and not enough focus on many of the essential activities required as part of the later phases (that is, the analysis of problems and identification of key contributory/causal factors).’

Others disagree altogether and are of the view that RCA is not effective and does not enable or encourage the assessment of human factors at all. For example, the Faculty of Intensive Care Medicine and the Intensive Care Society argue that RCA ‘has not helped so far. There is a limited published evidence base that a human factors contributory framework can assist in these types of investigation.’

The Faculty of Pharmaceutical Physicians of the Royal College of Physicians helpfully summarise that ‘...it is not the name that is attached to the analysis, but the manner in which it is conducted and how it is then followed up. This “follow through” is critically important and should be part of the National reporting.’ NHS England agree and say it is ‘the intent with which a particular model is applied that matters.’

**Perceived negatives/shortcomings of root cause analysis and positives of using HFA**

Many respondents expressed their view that RCA is more likely to lead to finger pointing and individual (55 times) blame (52 times). For example, the Royal College of Surgeons ‘strongly believes there would be benefits in ensuring a human factors assessment approach is used in local investigations as opposed to a root cause analysis. We are seriously concerned that individual healthcare professionals are sometimes prosecuted for GNM in the face of clear systems failures – perhaps because they are easily identifiable and immediately accountable when things go wrong.’

We are told that RCA is ‘over simplistic and reductionist’ because it ‘focuses on a sequence of events’ and does not adequately account for and address human factors (with the

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Muslim Doctors Association recommending a paper on the shortcomings of RCAs\textsuperscript{17}). Respondents generally argue that RCA ‘...takes human nature out of the process and creates a "who's fault was this" approach rather than a "how did this happen" approach.’

A Human Factors Consultant/Researcher argues that ‘...healthcare systems by their very nature are generally organic in their formation and complex in their structure. RCA is a methodology which is intended for linear and relative simple systems. Hence, I would consider there would be very few occasions that this method would be appropriate to the investigation of a healthcare system.’

The Royal College of Psychiatrists Scotland say that ‘...effective root cause analysis can systematically highlight constituent parts of systems which lead to failings. However, if root cause analysis is carried out too mechanically, the broader parameters and system pressures which doctors and other agencies are working under will not be acknowledged. Human factors assessment takes the position that humans are flawed, explores factors highlighting why errors were not picked up, and assesses the wider healthcare system.’ They add that ‘in the context of a healthcare system which is multidisciplinary, consists of multiagency personnel, and relates to system-based issues, it would be effective to take a human factors approach to local investigations.’ Similarly, the Intensive Care Society explain that ‘...Healthcare is a highly complex system, and even more so in fast-paced clinical areas such as critical care where the likelihood of error may be magnified. Root cause analysis may identify all the factors in a particular error, but may not alter the overall safety environment or the risk of a different error occurring in the same setting, due to similar and unaddressed human factors issues such as leadership, communications, workload and resources.’

Another individual respondent reports that in their experience of clinical incidents reporting, ‘group discussion seem to include some human factors in RCA.’ However ‘...although acknowledged the effect of human factors was not elaborate enough and did not contribute much in understanding the error. There is no tool for weighing such factors. RCA tends to rely exclusively on audit trails, failure to comply with established protocols and processes. When these are not met, no due consideration is given to the underlying reasons. There is a culture of culpability for not complying with trust protocols irrespective of the influence of human factors e.g. staffing issues, winter pressures, workload etc...’

One medical professional also advises that ‘most human errors don't have a 'root' cause, only myriad contributing factors. RCA should only be used for equipment and software issues’ Others add that pursuing a “root cause” is likely to lead to missing important contributing factors and therefore missing potential to avert similar events in the future, or that RCA produces recommendations that are not implemented/impractical because ‘...the RCA method tends to produce a multitude of recommendations as it does not cope well with the highly complex healthcare environment. Most of these recommendations are ignored.’ We are also told that the ‘key is to avoid a reductionist approach to a single root

\textsuperscript{17} \url{https://qualitysafety.bmj.com/content/qhc/early/2016/06/23/bmjqs-2016-005511.full.pdf}
cause (including an individual to blame)’ as ‘...too often the outcome of investigations is ‘adjust the guidelines’- which hardly ever get read or add another piece of paper / box to tick. Rather than ensure adequate staffing and resources.’

Respondents argue that HFA ‘better describes why mistakes happen’ and respondents also made a lot of reference to use of human factors analyses in airline Industry investigations.

In demonstrating the importance of the use of HFA, we are told that ‘...the RCOG’s Each Baby Counts programme (a national quality improvement programme) found that an average of six contributory factors could be attributed to the outcome of care in each case of stillbirth, neonatal death and brain injuries. This demonstrates the complex association between individual, system and organisational factors and the importance of assessing all factors within an investigation, including human factors.’

The GMC tell us that they support HFA and ‘...have met with leaders in the field of human factors to consider how we might ensure that our response to systemic issues is effective and reflects best practice. GMC also note that, 'In our outcomes for graduates we require that newly qualified doctors must be able to ‘...describe basic human factors principles and practice at individual, team, organisational and system levels and recognise and respond to opportunities for improvement to manage or mitigate risks’. In domain 6 of our Generic professional capabilities framework, covering Capabilities in patient safety and quality improvement, we say that: 'Doctors in training must demonstrate that they can participate in and promote activity to improve the quality and safety of patient care and clinical outcomes.’ To do this, they must... ‘raise safety concerns appropriately through clinical governance systems... demonstrate and apply basic Human Factors principles and practice at individual, team, organisational and system levels.’ They also highlight that the GMC is one a several organisations which signed the National Quality Board’s, Concordat on human factors, in 2013.

MDU also ‘...advocated mandatory human factors training for those involved in the prosecution process.’ And, they ‘expect it could be equally beneficial in local investigations ...it is a matter of good practice with patient safety incidents to investigate all factors that might have played a part in the incident, rather than concentrating just on one or more clinicians, and hope this will be borne out when HSIB publishes guidance for trusts on good practice in conducting investigations into patient safety incidents.’

The Academy of Medical Royal Colleges highlight their support of tools such as the recent ‘Just Culture Guide’ produced by NHSI building on the work of the ‘Incident Decision Tree’ which seeks to help identify and differentiate between individual and system issues.

An intercalating medical student undertaking an LLM in Medical Law and Ethics tells us that 'As a student doctor at the University of Liverpool such assessment of human errors have been given central importance in the feedback of Simulation Training for students. Further to this, alongside techniques (for example device design) to avoid human error, the analysis of human error has been key in implementing significant improvements to safety within similarly dangerous professions (such as the aviation industry).'
A Human Factors Researcher and Consultant recommends that the current serious incident reporting tools/software across the UK could be modified to ensure that all of the elements of the system are accounted for. They add that understanding contributory factors relevant to a particular outcome would be a more productive approach to healthcare investigations. If both positive and negative outcomes were collated in a particular context/environment it could possibly to understand how and why certain contributory factors are more relevant than others to a successful outcome.

Whilst the majority of respondents supported HFA, reasons given against wanting to introduce HFA or issues associated with embedding it in healthcare included the following concerns:

- **We [a healthcare provider] tried to do this but it was impossible to do rigorously because of the current national investigation tree frameworks**
- **The difficulty with HFA is that if it is carried to an extreme it has no particular consideration of how the working environment ought to be structured in an ideal world but merely addresses how it was structured at that time and what human behaviour resulted from that structure.**
- **HFA is unfair because it is very subjective as it lets people make judgements on character and personality and using opinions rather than facts to determine investigation results.**
- **The downside is that it might become possible for any poorly-performing doctor to cite human factors as an excuse for poor practice, as doctors always work in busy, under-resourced, stressful situations.**
- **MDDUS ‘have concerns about the suggestion that individual clinicians should routinely have their characteristics and personality traits assessed in the course of any investigation. We would question how this could be objectively and fairly achieved in the context of a local investigation; and we anticipate significant difficulties in terms of ongoing inter-personnel relations following any such assessment.’**
- **Legal professional: Care should be taken to separate the thinking around what the conduct was (and therefore characterizing it appropriately) and the consequences that should flow from that. If there is not such separation there will be a drift towards accepting lower health care standards in different settings. ...The human factors can be taken into consideration when looking to the consequential action. This may be via the protective jurisdiction of the profession regulatory (fitness in the UK), via the criminal law in the case of a matter that is proved beyond reasonable doubt as a criminal offence etc.**
- **Difficult Airway Society (DAS) Human Factors and Ergonomics (HF/E) group - System design using HF/E expertise can prevent an unsafe situation arising, or prevent an unsafe situation progressing to a point of no return, thus preventing an adverse event.... Such system design is incorporated into other safety-critical industries (for example the nuclear power industry, offshore oil, aviation, construction and rail), with HF/E experts playing a central role. In healthcare, designing safe systems has been very much more difficult than in other safety-critical industries, and as a consequence there has been more emphasis to date on one aspect of HF/E, non-technical skills: this includes behaviour, team work, situation awareness, task fixation, communication, decision making, leadership and flattening of hierarchies. However, the harsh reality is that however well trained staff are in this aspect of HF/E, if staff are then placed into flawed working systems then errors are inevitable. Healthcare is currently relying on unsustainable and unachievable high quality human performance to prevent adverse events occurring. Safer systems must be put in place to prevent or mitigate adverse events.**
- **Human Factors Consultant/Researcher - Currently despite NHS England recommendations of a human factors approach to the investigation of serious incidents, there is a lack of knowledge or capacity for organisations to draw on this. Frequently when they do the**
human factors knowledge may stem from an individual with no qualification in this field and a basic (and sometimes inaccurate understanding) of human factors.

**Other suggestions for implementation of HFA and practicalities**

We are told that the HFA/investigation needs to be independent and reviewed by peers/experts with no conflicts of interests - whatever approach is used the quality of the report will depend on the quality and calibre of the team involved in investigating the incident. Perhaps if these incidents were examined by personnel working at other trusts, there would be far less scope to cover up and a better platform for discussion and "openness".

Additionally, we are advised that the process needs investment in research, training and monitoring - a human factors approach is extremely important and ‘all managers and clinicians take part in RCAs should undergo training in this.’ The Doctors’ Association UK feels that human factors training for local investigators should be made mandatory.’ They also recommend that ‘...the Care Quality Commission look to examining trust compliance with this training as part of their review process.’ Some respondents go so far as to call for the review to ‘recommend human factors training as being compulsory for all doctors and fund it accordingly since an awareness of HF is critical to understanding how mistakes occur in the workplace.’

NHS Education for Scotland explain that ‘...currently in healthcare, human factors has often meant a narrow focus on Team Resource Management, but there is much more we could learn from HF/E. This may require an external body to investigate....It is often mis-interpreted as ‘factors to do with humans’. It is crucial to the understanding of why things go wrong as well as why things ‘go right’. NES has invested substantially in research in this field, and in the development of educational materials and training courses.18’

We are told that it is important to explain methodologies to patients and clinicians (some clinicians responding to this question appear unclear on the definitions). One respondent argues that ‘...it is very important that whatever system is used that the public can understand what is being done and that the methodology is not simply a way of covering up the problems.’

Other respondents raised concern that RCA/HF is not appropriately accounted for in criminal and coronial processes. We are told that ‘coroners and judges also need much better training in seeking and understanding the contribution of human factors and system errors in healthcare-related incidents. Their knowledge and acceptance of these as contributory factors, in my experience, is sadly lacking.’

A respondent advises that ‘...the non-technical parts of Lord Haddon-Cave’s Nimrod report should be mandatory reading for the whole working group. Chapter 18 is critical.19

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18 which can be accessed here: [http://patientsafety.nes.nhs.scot](http://patientsafety.nes.nhs.scot).
BMA add that ‘emphasis should be on early interventions and prevention rather than cure, to identify where system problems have occurred. This would assist with upstream regulation. The role of the Regional Liaison Officers of the GMC is key to this function as they are in a position to provide intelligence and feed into reporting mechanisms.’

RCP Edinburgh - There should be a set of standards for which data is collected and assessed for every prosecution in a healthcare setting. These should include but not be limited by: number and skill mix of staff; number and complexity of patients; presence or not of safety procedures including safety brief, multidisciplinary huddle, escalation policy; has individual/s accused recently returned from career break and if so, what support/induction was offered; were all staff present familiar with the unit or had they been adequately inducted; availability of senior decision maker/s and their communication with team if not on site.

Patient and family members

Patient and family member feedback is mixed, some welcome any and all analysis to ensure that a full investigation, accounting for factors is undertaken. Some are concerned that human factors means allowing these factors to be an excuse for poor performance, on the basis that systems should prevent issues such as over-working/staff shortages. The following comments are from family members:

- ‘Root cause is critical in the first instance but human factors also would be useful... However I doubt that the health service ever wants to get to the real root cause or causes.’
- ‘Yes there would be a benefit to ensuring a human factors assessment was carried out after an extreme adverse event. The doctor who overdosed our son, made a catalogue of bad decisions on the night our son died. Discovering the rationale behind those decisions will create future learning for new and existing staff. The doctor and nurse in question also made decisions not to share critical information with other staff in the room that night, the withholding of that information prevented our son from being given the best chance of revival. The Dr states on more than one occasion that he “trusted other members of staff had done the right thing”. This is an area that new and existing staff could learn from for future experiences, they should never be afraid to make sure that the team are in fact "doing the right thing.”
- ‘There is certainly a need to get to the bottom of serious failures which results in death or serious harm to patients. No stone should be left unturned.’
- ‘I am involved in debate with a small group of complainants and consultants. These words appear to be confusing. In my opinion it means human and individual characteristics. In others including those involved in PS Not so. I believe it is human factors characters mood etc that cause root cause problems. Human beings have to be made accountable for their mistakes despite their environment and working conditions. A sensible human does not put others at risk, despite stresses at work. To do so would be reckless behaviour. If they are stressed at work, then they should have the facility to immediately raise concern and demand assistance - eg an emergency button in each ward which goes to a staffing agency, paramedics or external body who can immediately send in assistance. It is should therefore be an offence to hide mitigating circumstances, personal or institutional which may lead to death of a patient.’
Question 18. Typically who is involved in conducting investigations following a serious clinical incident, and what training do they receive?

There were 513 responses to this question online. The word ‘unsure’ was used 19 times in those responses.

Who conducts the serious clinical incident investigation?

- Incident team (‘incident’ – 41 times) / quality team (‘quality’ – 18 times) / trust (‘trust’ – 63 times) / risk (‘risk’ - 34 times) / management (‘management’ - 51 times) team / clinical governance team (‘clinical’ – 115 times) / safety team or leads (‘leads’ – 19 times) / ‘Panels consisting of a majority of middle-to-senior grade managers and a minority of clinicians with at least a part-time commitment to management.’
- Heads of department (‘department’ – 34 times) / senior staff (‘staff’ – 61 times) / senior clinician(s) (‘senior’ – 139 times and ‘clinicians’ 60 times)
- ‘Another clinician usually a consultant from the same trust but not department’ (‘clinicians’ – 60 times/consultant(s) (‘consultants’ – 40 times and ‘consultant’ – 29 times)
- Manager(s) (‘managers’ – 74 times and ‘manager’ – 54 times)
- Director(s) (‘director’ – 52 times and ‘directors’ – 17 times) / medical executive members (‘medical’ – 73 times and ‘members’ – 19 times) / board (‘board’ – 23 times)
- Healthcare professionals/ nursing managerial staff (‘nurse’ – 37 times and ‘nursing’ – 29 times)
- Lawyers
- Patient Advice and Liaison Service (PALS)
- In relation to the primary care setting typically respondents said that it is usually the practice manager (‘practice’ 44 times) and others said they are done by one or more GPs, a senior partner or by/with the CCG. NHS England (NHSE) advise that in primary care ‘initial service issue would be managed by NHSE’s local quality team.’ Then if ‘issues are identified it will be managed within the Framework’, however they recognise ‘there is local variation in the handling.’

Less frequently mentioned or sole mentions included:

- Senior pathologist
- Consultant anaesthetists
- Medical expert witness
- The Responsible Officer
- The National Clinical Assessment Service (NCAS)
- Junior member of staff, with little insight into the complexities of clinical care.

We were also told that patient families and carers are involved in investigations.

The Doctors Association UK (DAUK) (as well as many other respondents) describe the variability in who or which team conducts local investigations saying that ‘...there is a paucity of guidance as to who is expected to conduct investigations following a serious
clinical incident and the training they should receive. There is a tremendous amount of variability from one healthcare provider to another. Even within many organisations there is no set policy on who will conduct these investigations, with the investigator seemingly being selected on the basis of whoever is available. This clearly cannot be best practice in ensuring that a robust and fair investigation is conducted. In the event of a conflict of interest expressed by a staff member it is imperative to ensure that the investigator is independent and impartial. This may require an external investigator. DAUK feels that it is paramount that cases involving doctors should have a suitably qualified and experienced doctor on the investigation panel, the same should apply to all staff groups.’

Similarly, NHS Improvement advise that ‘...there are different approaches in different organisations. Some organisations have dedicated investigators but too often, investigators are clinicians or managers (with other ‘day jobs’) and who have had limited training in the science and art of investigation. They may not have even had an opportunity to shadow or seek support from experienced investigators before they are asked to lead their own investigation for the first time... In addition, investigators often have to work additional and unpaid hours to complete SI investigation work and therefore have limited time to spend on this task. (Because current national deadlines are impacting the quality of investigations, these deadlines are under review as part of the ‘Future of NHS investigations’ engagement work.)

Other comments specifically relating to those conducting investigations included:

- that there is variability in who ‘leads’ the investigation – a respondent tells us that ‘...it seems that incidents are investigated according to the seriousness rating. This can be as simple as local line management or up to the Serious Incident Review Group. ‘ Another says that ‘...an SUI is usually led by a clinician trained in Level 3 investigations from a different department or CSU. They are usually supported by an administrative process. Lower level investigations have less resource allocated and are usually internal to a department or CSU.’
- Investigators should have some ‘psychological sophistication. Lawyers are not always the best people to lead an enquiry as they can be too adversarial. When I was involved in serious untoward incident enquiries my training as a psychotherapist was valuable - it included being able to help with conversations both with professionals and family. Having group skills was also useful.’

A number of respondents shared areas of perceived good practice they have experienced. For example a medical professional tells us that they ‘had a huge improvement in the effectiveness and patient experience of complaints when we appointed a senior midwife to organize investigations and liaise with patients and families. She had a lovely manner and was an expert in her own right. Unfortunately when she retired they went back to someone non-clinical so all the things she would have settled quietly will now blow up again.’

Another shares that ‘... In obstetrics we have at least one senior "risk" midwife who leads on investigation in association with a named consultant and other members of the senior team. There is a maternity safety champion on every trust board and most trusts are now employing a Risk lead for the whole trust to bring in investigation in other divisions along the lines of how this has been done in maternity.

**Suggestions for improvements**
Respondents made the following suggestions for improvement:

- A less experienced investigator would be paired with a more experienced one.
- Faculty of ICM/IC Society – ‘NCAS has clear processes and standards for investigation of incidents involving conduct of medical staff under MHPS. A similar process of clear standards and training of investigators is needed for review of these incidents. This may be best done through a national process or body eg NHS Resolution.’

**Training of those conducting investigations**

BMA explain that while ‘variability in respect of who is involved in conducting investigations is of some concern, our greater concern lies in the lack of training which is being provided to those involved. Such a lack of training will lead to an inconsistency of outcomes. While we do not doubt the good intention and professionalism of the staff involved in conducting those investigations, without consistent training, we are concerned that due and fair process will not always be followed.’

The majority of respondents said there is no training of those undertaking investigations. That the training is/was minimal, lacking, focusses only on processes, and/or, is highly variable. Others said that they did not know, or words to the effect. A number said that investigators are reliant on, 'on the job' experience in lieu of training.

The Royal College of Obstetrics and Gynaecology (RCOG) highlight that ‘...training is reported as often being only half a day, with no top-up training. The RCOG would like to see greater value placed on training, where employers view it as an investment to improve skills and culture. This would include better resourcing of training but also employers being much more willing to release staff to participate.’

Overall, we were repeatedly told that there is a significant lack of training in Human Factors/Root Cause Analysis/risk management, with one medical professional telling us that ‘...the training my Trust gives plays down the contribution of organisational and cultural aspects.’

Some examples of existing training given by respondents:

- Root cause analysis (RCA)
- Significant event analysis (SEA)
- Training in investigating SIs and writing the report.
- GPs are trained in conducting regular significant event meetings in house and most have experience of trying to see how these matters raised and how they might be avoided in the future.
- A consultant is trained by NCAS or the organisation in how best to undertake such an investigation.
- One respondent tells us that ‘...Training for Consultants is poor’, whereas ‘...Emergency Medicine trainees receive good experience and practice via management exams and management portfolio work.’ However this respondent is ‘not aware of any other specialties receiving any other similar training. Their ‘trust
runs a one day course for senior managers including consultants on clinical risk management but this is not mandatory and is poorly attended.’

- We are told that at London School of Tropical Medicine [those investigating] are asked to participate in patient safety training similar to that promoted by the Institute for Healthcare Improvement.

- Royal College of Psychiatrists Scotland say that ‘...Presently, there are undesirably broad variations between Health Boards across Scotland. However, there are examples of good practice, such as NHS Grampian which has instigated training in ‘significant adverse event reviews’.’

- Royal College of Physicians and Surgeons Glasgow advise that ‘...some trusts provide risk-management training for senior staff, but training to lead Morbidity and Mortality meetings or Schwartz Rounds is not provided, nor is training regarding appropriate family communication relating to such incidents. The Scottish Morbidity and Mortality Programme has recently produced a guidance document with clear recommendations for best practice in this area.’

- NHS Education Scotland ‘is doing some excellent work on Human Factors training for investigations but I think fundamentally we need certified HF practitioners in every Health Board. I would love to have the time to be trained but as it stands the MSc and other courses in HF require at least 15 hours pw and cost significant amounts even for a 1-3 part time course and I can’t fit that in around my clinical responsibilities.’

- A couple of doctors referenced the potential to learn from AAIB investigations with respect to training given to investigators and the language ‘used in AAIB investigations which are written in a very balanced and neutral manner, eg The Shoreham airshow disaster report but also that once complete these reports are in the public domain.’

**Issues/concerns/suggestions about investigations or investigators more widely**

A number of respondents reported other issues or concerns about investigations more widely. These comments reflected recurrent themes arising in responses to previous questions, including that:

- Staff need to be given time (as a requirement on organisations) to attend reviews.

- There is a need for an administrative team to support the investigation process

- Concern those doing/leading investigation are often non-clinical and/or well-removed from clinical practice. Need to involve someone with experience of specialty and current frontline experience of ‘life on the wards’

- A few individuals commented that ‘there’s less acknowledgement of the effect on the individuals involved, and that this is important.’ It is likely that these respondents are referring to the second victim phenomenon.
The Royal College of Anaesthetists say they ‘...are especially concerned by the time constraints imposed by managers to which investigators are expected to work to, greatly inhibiting their ability to examine complex incidents in depth. Moreover local investigators are not always released from their clinical duties and often need to try and fit investigations in between shifts or as part of their already small Supporting Professional Activity allowance.’

Perceived or actual bias by investigators was commonly reported in responses to this question. Respondents say that ‘clinicians, typically clinical managers may be biased consciously or unconsciously to organisational priorities’ and they are often the ones carrying out the investigations. We are told that in primary care SIRs are carried out by the line manager or senior partner of a GP practice. This creates conflict if there is already tension between individuals or if the person in this role is trying to deflect blame from themselves. More generally we are told that ‘often it has been someone who has a clear conflict of interests e.g. the supervisor of a key player.’ Therefore there needs to be impartial assessment by appropriate experts - perhaps credentialed by appropriate bodies.

The majority of patient or family member responses equally indicate strong perceptions of bias of investigators/investigations. One tells us that in their case, ‘...it appears that the only people involved were the perpetrators who were hardly likely to find themselves at fault.’ Another adds that ‘...The Trust Complaint system denies the truth. They are biased. The system has to independent.’ Again another family member explains that ‘clinical incidents and complaints in general are investigated by staff members within the trust complained of. With the ultimate person accountable being the Chief Executive of the Trust. All NHS Trust have a published procedure for the investigation of complaints including those defined as “Never Events ” including death....I have no idea what training an staff investigating complains has been given.’ Additional another family member tells us that investigations are conducted by ‘...members of the administration team of a trust, the chief executive and the medical director. Often the medical director is the one who has made the serious clinical incidence, and therefore has a conflicting interest. The chief exec always sides with the medical director, therefore the investigation is a scam and not impartial. Not aware of any training received.’

Respondents often advised that ‘investigations should involve someone external/independent’, and one respondent adds that ‘in other safety critical industries, investigators are external, and in highly technical environments, investigation is a full-time role undertaken by specialists who do nothing else. Often this function is provided by the state - eg air accident investigation, rail investigation. There may well be a case to be made for healthcare deaths, too.’
Question 19. How is the competence and skill of those conducting the investigations assessed and assured?

There were 505 responses to this question online.

Lots of respondents said that they didn't know, were ‘unsure’ (22 times) or words to that effect. Many others said that the competence and skill of investigators wasn't assessed or assured at all. Others gave their views on some existing (usually informal) mechanisms of assurance or scrutiny, but these were mostly in relation to the robustness of the investigation or report, rather than the competence or skill of those conducting investigations (investigators). Such examples were comparatively rare but included for example, the word ‘appraisal’ which was mentioned 17 times and ‘revalidation’ 11 times.

The BMA told us that …‘there is no assurance process in place. This, along with the lack of training available for those conducting these investigations, is extremely concerning. People conducting investigations need to demonstrate they have the appropriate skills and level of competence to make a judgement on the course of action to be followed if the investigation findings indicate there may be a concern about one or more members of staff.’

Similarly, the Royal College of Anaesthetists argued that …‘Quality assurance (QA) in local investigation is undoubtedly an issue that needs to be addressed....QA for these roles is still inconsistent in many hospitals and too often negatively impacted by a desire to meet deadlines, rather than how rigorously and sensitively the investigations are conducted.’

The Royal College of Obstetrics and Gynaecology agreed that …‘Often, those involved in investigations at a hospital, trust and board level have little and limited training that would assure their competence... standardised training on dispute resolution at a local level would help address the variation among investigations and would also increase the publics', and doctors’, trust in the process.’

One relative of a patient ‘was an elected Governor at a local hospital for 6 years’ and felt this experience showed how poor local investigation standards are. They recommend that ‘...staff carrying out investigations need much better training, to include Human Factors and Whole System Safety.’

Some said that investigator’s skills or competence were assessed/assured to some degree but that it was either informal or done badly. Medical professionals told us in their experience they haven’t been assessed/assured and that they never received any training before they conducted root cause analysis or serious incident investigations. With one asking...‘how can this be right? There are crash investigators in rail/plane investigations so why do we think the complexity of healthcare investigations can be managed by clinicians with minimal / no training.’ And they add that is very little 'professional' admin support and very poor IT/ incident reporting systems.

As we saw in the recurrent themes to the questions before this one, a few highlighted perceived bias in local investigations because of the individuals selected to conduct investigations who are viewed as having a vested interest in the outcome. They indicated that selection of investigators is informal and often based on those locally who have past experience or seem to have relevant skills. A couple expressed concern at the selection
process for investigators, saying for example that appointments are usually ‘political’. In addition to this, a number of medical professionals highlighted that this issue of perceived bias is compounded because of the lack of ability to challenge the findings of an investigation and/or the conduct of investigators.

Examples of assurance mechanisms that we were told are in place:

- Whilst ‘individual competence is not assessed’... scrutiny of investigations is carried out by some form of panel or team ‘that vociferously suggest modifications’:

- NHS Providers (whose submission was completed with information provided by 27 foundation trusts and trusts) advised that local ‘...internal governance mechanisms are the most common means of assuring the quality of SI investigations and of the skills of those conducting them....While there is no process for assessing the skill and competence of investigators, the SI reports are treated as an indication of the technical skill and rigour of the investigators. Trusts advised that they have regular scheduled serious incident review panels...panels offer the opportunity for factual accuracy challenges to be put to the investigators'. NHSP suggested that 'guidelines could be produced by NHSI as to what constitutes a well-resourced patient safety investigation function according to the size and type of trust.'

- Another respondent says...'Reports are submitted to a committee of about ten people for full judgement which covers compliance with the methodology, thoroughness and recommendations made. Only when they have passed the report - usually with alterations - will it be completed.’

- Similarly, others tell us that they have scrutiny by ‘...a governance committee,’ ‘a multidisciplinary panel,’ ‘a committee comprising doctors and patients representatives equally,’ ‘a patient safety team’ or ‘a formal committee including the director of nursing and the medical director and then again by the CCG and then again often by the coroner and then a sample by the CQC and another by NHSI.’

- We are told that investigation reports ‘are always brought for discussion, as each member has a slightly different perspective and will have different questions to ask of the case. This means that the information presented and the investigation is constantly peer reviewed and more information can be asked for. When taking on this kind of work a midwife or a consultant will be mentored by someone more experienced in this field, as it is recognised how important it is to investigate thoroughly and get it right for all involved.’

- A number of respondents highlighted the training of investigators (or their expertise) as a mechanism of ‘assurance’, for example, ‘local investigating teams are centrally supported by Quality Risk Facilitators who have investigator expertise.’ NHS England says that investigators would be expected to undertake relevant NCAS training. They add that in the vast majority of primary care investigations that investigators will be Performance Advisory Group members, who have standard training, can calibrate each other’s actions/views, and can share good practice. Similarly, a GP tells us that ‘...Serious incident investigators have experienced managers with oversight of the entire process. QA systems are in place to ensure tried and tested processes are followed and that no investigator bias colours the process.’ However, this respondent does not describe what those ‘QA systems are.’
• One respondent tells us that there is no formal assurance process. And that they rely on their own staff to conduct investigations, ‘with variable results.’ But, they say that they ‘personally read all the SI reports that go to StEIS and actually have a lot of assurance about what we do.’

• One medical professional views ‘It is an improvement that currently all investigation reports are discussed with relevant people before sending them to the board/CCG, after a suggestion from the medical staffing committee.’

• Peer to peer assessments (‘peer’ mentioned 12 times) and/or external assessment.

• A few simply indicated the oversight that would be provided through appraisal and revalidation, where investigations formed part of a doctor’s ‘whole practice’.

Some questioned/criticised the training for medical examiners and/or for GMC investigators.

**General agreement and support for the need for training and QA of assessors and the process and outcomes.**

Suggestions for improvement of assurance mechanisms included:

• ‘NCAS training is a good starting point. However, if investigation became more routine and integral to healthcare, then there would be a wider base of competencies for investigation and also greater peer review and support for investigation.

• Needs to be standardised and need specially experienced and trained clinicians and legal advisors in a team structure with protected paid time to perform this work correctly

• Needs to be peer-review of assessments by clinicians

• Communication skills training is vital as part of assurance. Including assessment of listening skills and ability to discern what is relevant.

• There must be a hospital committee (Mortality Team), which must ensure that investigator has taken all steps ensuring it is fair and robust, the lessons learned and the improvement or change has taken place.

• Investigators with experience of the specialty in question, and relevant specialist training, eg in academic background to Risk Management, RCA, and HF...

• Important that the investigator offers appropriate challenge.

• There is much that can be learned from the neutrality of language that is used in an AAIB investigation. For example see the AAIB report for the Shoreham airport crash-which concluded pilot error as the cause, but not pilot blame.

• A few respondents were keen that the review did not recommend mandatory training for all in this area, ‘efforts need to be targeted to a few individuals who will then do investigations on a more regular basis, and have time allocated in their role for this.’

The Royal College of Physicians, DAUK and Association of Surgeons in Training (ASiT) highlight that there is currently no record of competence or skill of investigators that they are aware of. They say that the competence and skill of those conducting investigations should be predefined, standardised and accepted by all stakeholders. There must be independent criteria for establishing the competence and skill of those conducting investigations. The criteria might include a requirement that the investigation be conducted by people not employed by the hospital or trust.

The Royal College of Physicians and Surgeons Glasgow call for ‘Standard methods of training and support to be instituted at a national level.’ Arguing that the ‘Royal Colleges may have a role in this provision.’ Similarly, DAUK call for ‘mandatory training on conducting investigations and on human factors is required. We would also ask that this training is regularly refreshed and that it forms part of the CQC criteria that is examined when inspecting a healthcare provider.’ Similarly a patient or family member ‘stronglysuggest[s that] any assessment or assurance should be carried out by an independent body.’ Alternatively, Faculty of Pharm Med, RCP advise that through the governance ‘...committee the Board should work with the executive directors and managers to ensure that there is a trained and experienced team who can undertake the investigation. It is often the case that the Medical Director as an executive undertakes the leadership of this team. There is a need for specific skills to be learnt, for the roles described above. This should be part of the requirements for an individual taking up the role of Medical Director.’

Academics who responded to this question advised that there should be clear criteria for the selection of investigators and ‘a competent method of assessing performance’. Including, ‘regular assessment, regular updates of the latest practice as well as ensuring that those conducting the investigations are very familiar with current practice on the shop floor.’

ASiT also ‘...welcomes recommendations in the Williams Report for the development of high quality training for, and robust assurance of, these experts. Specific reference to the importance of equality and diversity assessments is required in both GNM investigation and fitness to practice hearings. ...A structured Healthcare Safety Investigation Branch (HSIB) in cases of GNM, for example, would further streamline the ability to structure and standardize GNM investigation and management.’
Question 20. In your hospital/trust/board or other healthcare setting, is there a standard process/protocol for conducting investigations following a serious clinical incident leading to a fatality?

There were 391 responses to this question online.

- 140 they ‘did not know’
- 37 said ‘no’
- 128 said ‘yes’ there is a process or protocol, but a number said that they didn't know where it was/how to access/or if they ‘could share it’, and some even indicated a fear of sharing this.
- Also a number of respondents said they ‘presumed so’.

About 50 respondents provided examples of processes/protocols, which included:

A number of respondents advise that the ‘national standard (in England) is set out in the Serious Incident Framework (SIF) (March 2015).’ However, they say that this is adapted (and most commonly a shortened, ‘processed’ and/or simplified) locally so ‘there is a lack of standardised good practice. This is something NHS Improvement is looking to improve through their current work programmes.’ At the time of this call for written submission evidence, there was a recent consultation on revising the SIF and it is due to report later in 2018. NB: there is a standard policy to support the review (rather than full investigation) of certain deaths. This is described in the Learning from Deaths Framework.

A number of respondents also pointed to other national guidance or local protocols/policies, including:

- The National Patient Safety Agency ‘Incident Decision Tree20’ recently changed to NHS Improvement’s ‘a Just Culture Guide21’
- Significant Event Analysis (SEA) proforma online – (mentioned 4 times)
  - We are told that the SEA report is prepared and presented to all practice clinicians for comment and learning.
  - One respondent highlighted Healthcare Improvement Scotland's guidance on Significant Adverse Event Reviews.
- One respondent tells us that they have a ‘declaration meeting to ensure it meets the criteria to be an SI, then a 72 hour review , then the full Ix.’
- RCA protocol/template (mentioned 6 times. A few also mentioned meetings to discuss the RCA)
- Morbidity and mortality (M&M) meetings (mentioned 4 times)

• A number of responses referenced the involvement/referral of reports/incidents to the Board or senior managers.

• Royal College of Physicians, structured judgement review (SJR) was mentioned by a couple of respondents.

• A couple of respondents also referenced Datix.

• A few mentioned need to report to other organisations eg, CQC and CCG.

• A couple of respondents referenced the need to refer to a pathologist, or that the investigation is led by Coroner.

• A few respondents highlighted discussions of events with the team/practice managers.

Other processes suggested by individuals included:

• Primary care practice’s complaint’s protocol.

• Strategic Executive Information System (StEIS) process (national).

• Clinical review groups.

• Health and Safety Executive (referrals to?).

• expectation that they carry out ‘a 24 hour Fact Find Report.’

• Patients Advice and Liaison Service (PALS) complaint procedure.

• Regular serious case reviews.

• Quality and risk department as well as (local) policies.

• Individual NHS board processes for suicide reviews (Scotland)\(^2^2\)

One respondent informed us that ‘All NHS trust and GP surgeries are obliged to publish their own internal complaints procedure for public consideration. The procedure has to follow the legislation laid down in 2009.\(^2^3\)

Some respondents gave their views on the (lack of) effectiveness of protocols and policies for serious clinical incidents, for example:

• ‘Learning from Deaths (LfD) has been a very crude approach so far. We also need to consider how the LfD agenda applies to community services- it is very unhelpful to be asked to try to investigate hundreds of deaths of people at the end of natural life as if there were root causes to be found in the service response.’

• ‘Protocols exist in most health care settings but, their implementation is highly varied and there is a lack of governance and accountability.’

• One doctor in training noted that they don’t know because they change hospitals every few months. They also highlighted the lack of time they have to carry out what is expected of

\(^2^2\) [http://www.knowledge.scot.nhs.uk/suicidereviews/ga-flowcharts.aspx](http://www.knowledge.scot.nhs.uk/suicidereviews/ga-flowcharts.aspx)

them already (without reading local policies/protocols) also saying...This is also why trainees need to be protected because we need to adapt to new systems and hospital policies regularly.’

- The BMA argue that ‘...while it appears that in some places there is a standard protocol in place for conducting investigations, there is no consistency in relation to those processes across trusts in England. We think it very important that Local Negotiating Committees are involved in the drafting of those processes and that, while allowing for locally negotiated variability, they should be as consistent as possible. In addition, once established, we believe that the HSSIB will have a role to play in sharing with trusts their learning from investigating serious incidents and providing advice and support in how Trusts implement their own approaches. Equally, just as important as having an agreed process in place is ensuring that clinicians are aware that it exists and can easily access it if necessary.’

Analysis of serious clinical incident policies and guidance documents received from respondents

We received 10 serious incident policies and/or guidance documents all of which reflected the Serious Incident Frameworks applicable to their respective countries. We received documents from Scotland, England and Wales, not Northern Ireland. Although a small sample, the policies varied considerably in their tone and guidance. It was noticeable that certain documents clearly emphasised the need for an open and transparent approach to investigations which encouraged a no-blame culture of staff involved in the incident. In comparison some documents did not emphasise this approach and instead focussed on the processes required to complete investigations and subsequent reports within a designated time frame.

Importantly, some frameworks heavily referred to support for staff involved in incidents and recommended the use of various support services. There was also some policies that provided training opportunities for staff members who were conducting investigations.

There was a difference between policies in how much guidance was provided to staff on how to communicate the investigation process with patients and their families. Some policies only included a small paragraph whereas others included entire sections on why it was important to involve the family in an investigation and how to do this in an appropriate way.
**Question 21: What measures are taken to ensure the independence and objectivity of local investigations in hospital/trust/board or other healthcare settings?**

There were 447 responses to this question online.

- 195 respondents were ‘unsure’ about what measures are taken to ensure independence and objectivity in local investigations (or used words to that effect).
- 82 respondents said there are ‘no measures’, or very few measures in place. Four of these respondents said ‘the professional duty and integrity of the investigator is relied upon.’

We were also repeatedly told about the problems with there being no, or very few measures in place, with the National Guardian’s Office highlighting that ‘...the lack of independence of investigations, both actual and perceived, undermines the legitimacy of such investigations, which ultimately risks putting patients at risk and discourages workers from speaking up.’

As we have seen in the recurrent themes to previous responses to questions, in addition to respondents stating that there are no, or very few, measures in place, 16 respondents from the medical profession appeared to suggest that those responsible for local investigations were biased or discouraging objectivity and independence. Examples include:

- ‘The Trust often has a vested interest in these - not enough staff for example - and may obviously seek to shaft the clinician involved.’
- ‘They have a lawyer but their main aim is to reduce their liability.’
- ‘The first people might be open and helpful, but their bosses might change the slant of any report.’
- ‘None from the investigation that I have been involved in. The local investigation included the consultant and senior nurse involved in treating the patient. It then involved colleagues of the consultant who were supportive of the consultant but not of the "temporary" junior doctors who are on rotation.’

Additionally, as we have seen in recurrent themes to previous questions, a number of respondents highlighted perceptions of blaming/scapegoating individual doctors. In particular, Dr Vaughan says that, ‘across the NHS and private healthcare system there is evidence that providers will single out individuals rather than be transparent about their own errors.’ This view is shared by the Royal College of Pathologists, who noted that ‘the rules and definitions of serious incidents are highly open to interpretation. Serious incidents can be used to victimise certain employees. Whistle-blowers are often held to higher standards than other employees. Independent and lay observers should be involved.’

The National Guardian’s office told us about a recent published case review report\(^{24}\) which concerned the handling of speaking up cases at a particular NHS Foundation Trust. They tell us that one ‘speaking up case lasted over 20 months, partly because the investigators the trust had appointed were deemed not to be suitably independent by the individual who

\(^{24}\) [https://www.cqc.org.uk/sites/default/files/20180620_npo_derbyshirecommunityhealthservices_nhsft-case_review_speaking_up_processes_policies_culture.pdf](https://www.cqc.org.uk/sites/default/files/20180620_npo_derbyshirecommunityhealthservices_nhsft-case_review_speaking_up_processes_policies_culture.pdf)
had spoken up. This resulted in an extremely delayed speaking up investigation which was not in accordance with good practice, namely that investigations are timely and appropriately independent.’ As a result they recommended that the trust undertakes to ensure that investigations into its workers’ speaking up issues are appropriately independent. They also identified that there ‘was limited guidance available for organisations on how to carry out appropriately independent investigations.’ So they also made a recommendation to the Department of Health and Social Care to commission the production of such guidance by NHS Employers, to be commissioned within 12 months of the publication of the case review report in June 2018.’

**Measure: External involvement with the local investigation**

58 respondents suggested there was some external involvement with the local investigation, making it the most common measure to ensure independence and objectivity. For example, the vast majority of those 58 respondents said that ‘other organisations were involved in the investigation.’ Four respondents said ‘professionals from a different, internal department were involved in the investigation.’ One said to use someone ‘not from the case’, but it isn’t clear if they thought this was current practice or should be what is done.

A couple respondents stated that the investigator ‘has no connection to the incident’, however it was unclear how this was achieved and whether they could still be from the same department or team. Based on responses to this question, it would appear that the extent of involvement from other departments and/or other organisations varies considerably (by department, specialty, or healthcare provider).

We are told that ‘…national guidance and training materials advise that staff who work within the clinical area/department/directorate in which an incident occurred should not be appointed to lead or assist in an investigation of that area. However, this advice is not always followed.’ A couple respondents highlight that there is an ‘…informal preference for the investigator to be in a separate directorate from the one in which the incident occurred.’ Or, that healthcare providers ‘…try to use people from other departments. However, unlikely in any hospital that these people are truly independent.’

A number of responses indicated that the severity of the incident can act as an influencing factor as to whether external opinions are sought, saying for example:

- ‘Occasionally we will seek an external investigator (very serious incident or very small and specialised service (eg corneal transplant service which is single-handed)’
- ‘Rarely, the trust may ask an independent consultant or nurse in the same speciality from another trust to give an opinion about a case, but this usually only happens if there is litigation.’
- ‘Investigators are from outside the division in which the incident occurred, but external reviewers are not used. SI reports above level 4 are reviewed by the CSU and CCG.’
- ‘In most cases this is impossible because the resource implications are enormous. A couple of times a year we pay a lot for an independently chaired report, and when this is into a mental health homicide it is also followed by an NHSE commissioned independent investigation. These are often very interesting reading but usually too late, too hindsight biased, and aimed at the rarest and least preventable event in mental health.’
One respondent from the medical profession commented that ‘...only if the family request it we will have an external opinion on a serious incident and send the data out to another organisation.’

**Other measures for ensuring independence and objectivity of local investigations**

The following measures were also mentioned by respondents:

- Conflicts of interest declarations
- Ensuring patients and relatives are aware of NHS ombudsman
- Equality and diversity training
- HR representation
- Clear brief and reporting arrangements through to Board
- Offering a patient adviser to the family/patient
- Involving a lay representative in the investigation, usually from one of the provider’s committees (eg the ethics committee) or on the LMC and PAG. Although it’s worth noting that we were also told by another respondent that ‘...lay representation other than non-executive board members is often quite rare partly because interested representatives are often in short supply and are required on many different committees and in many different roles, for which they often receive no remuneration.’ And another highlights particularly that there is ‘no true lay representation’ on their review committee.
- Involving staff from other disciplines, (with a number of respondents mentioning senior nurses).
- The National Guardian’s Office (NGO) provides challenge, learning and support to the healthcare system as a whole by reviewing trusts’ speaking up culture and the handling of concerns where they appear to have not followed good practice. (1 respondent)
- Escalation to the ‘Ombudsman’ (perhaps the Parliamentary Health Service Ombudsman)
- HSIB seeks to establish independence ‘but, even if it does become fully independent, it can only undertake a small number of investigations, so the NHS needs to establish better/ more credible internal processes too.’

As we saw in responses to question 19 (about assurance mechanisms for the competence and skill of those conducting investigations) we were told again here by a respondent that ‘...every report is scrutinised by a formal committee including the director of nursing and the medical director and then again by the CCG and then again often by the coroner and then a sample by the CQC and another by NHSI.’

**Practical challenges to independence and objectivity**
NHS Providers stated there is a range of practical challenges to maintaining investigation approaches that exemplify the highest levels of independence and objectivity at all times. These include:

- Capacity of suitably skilled staff.
- Some investigations require specialised clinical knowledge that can only be found in the team/division in which the incident occurred.
- High cost and delayed availability of suitable external investigators.
- Very difficult to find outside expertise that understand the ambulance landscape.
- Constraints on capacity means sending consultants and operational managers to routinely do investigations in other trusts is not feasible.
- Difficulties in engaging some patients and families due to grief, refusal or unavailability.

Variability in the quality of measures used across local investigations

9 respondents noted that there a is wide variation in the quality of measures used across local investigations. Dr Jenny Vaughan commented that, ‘...when hospitals conduct investigations there is too much variation in how they are done.’ Both the British Medical Association (BMA) and Academy of Medical Royal Colleges (AMoRC) concurred with this view.

Some other respondents made also suggestions for how the independence and objectivity could be enhanced:

- Make the person in charge of local investigations independent and not directly answerable to the trust management. They should be employed by an outside organisation.
- Final decision making meetings around the outcome of serious incident investigations could include a lay person (probably with legal or senior management expertise) and a non-executive from the trust board.
- Another says it should be a lay chairman of the review or all lay members with medical expert input if the case is ‘sufficiently serious’.
- A balanced independent organisation comprising medical, legal and lay representatives, but NOT the GMC!
- There ought to be a fair and independent national expert body of troubleshooters, as the Royal College of Surgeons used to have (fast track).
- Ensure HR representation.
- Ensure clear brief and reporting arrangements through to Board.
**Question 22. What is the role of independent medical expert evidence in local investigations?**

There were 464 responses to this question online, along with 21 written responses. A large proportion of responses were that they ‘don’t know’ or words to that effect.

- 20 responses were from a professional representative/membership organisation, college or trade union (13 written, 7 online),
- 15 were from patient or family members of a patient (2 written, 13 online),
- Two were from medical defence organisations (1 written, 1 online). Another two were from systems regulators (1 written, 1 online).
- Four were from a voluntary organisation/charity (1 written, 3 online).
- Nine Academics responded online and four Legal professionals.
- The vast majority of responses were from individual medical professions (407 responses: 1 written, 406 online). The rest identified as either ‘other healthcare professional’ or ‘other’.

A significant proportion of medical professionals who responded simply stated that there was no independent medical expert involved at the local investigation level, for example a respondent told us that ‘...After 30 years in the National Health Service I have never seen an independent medical expert involved in a local investigation.’

Some respondents indicated that whilst there was currently no role for/use of independent medical experts at local level, they would welcome an outside perspective. One respondent called for more than one, saying that there should be two from two different healthcare providers.

Simply put, the majority of doctors said that the medical expert’s role was or should be to provide an impartial view of the matter under investigation, thereby reassuring all parties and giving confidence and credibility to the findings of an investigation.

Several respondents indicated that there was no role for an independent medical expert because it would be ‘premature’ or otherwise inappropriate, for example a respondent who claims it is ‘not as relevant in primary care, but secondary care sometimes try and impose it’ and another who says that if they ‘hear the phrase ‘independent expert’’ they assume, ‘something political or dodgy is going on generally.’

Many respondents indicated that whilst involving an independent medical expert in local investigations ‘may increase fairness’ they say it is expensive/resource intensive and not a priority at local level with ‘significant pressure on resources.’ Therefore, they ‘tend to avoid using it due to cost’ and ‘use other local staff as cheap.’ One respondent adds that ‘...in mental health it is hard to know how valuable it could be.’

**Meaning of an ‘independent expert’ and variation in the ‘role’**

The GMC’s response states ‘It is worth recognising that there is not currently a shared/agreed understanding or definition of what ‘independent expert evidence’ is or who should be recognised as an ‘expert’.

Individual medical professional respondents also query the definition, pointing out that the term ‘independent’ could mean many different things in the context of local investigation – ‘independent of the:

- care of the patient
Independent review of gross negligence manslaughter and culpable homicide

- department in which it occurred
- hospital or practice
- trust/health board (where there is more than one hospital)
- region/country
- NHS/Department of Health?

NHS Improvement also questioned the meaning of ‘independent medical expert’ in terms of local investigations, and said that generally ‘...an investigation team must include or have access to expert clinical advice relevant to the type of care being investigated, but sufficiently separate from the specific care in question, so that current normal practice can be understood and compared with what happened during the events in question. This often entails seeking advice from other organisations (and therefore adding an element of independence).’ The phrase ‘sufficiently separate from the specific care in question’ indicates that NHS trusts and health boards see an ‘independent medical expert’ as someone who works for the same organisation, perhaps in a different department or hospital. NHS Improvement added that other than neighbouring organisations, the Royal Colleges may also be asked to provide a subject matter expert review which can ‘give a more objective opinion’.

The Royal College of Radiologists also said ‘...there does not appear to be a defined recognised role’ and the Royal College of Pathologists simply said the role was ‘variable’. The Academy of Medical Royal Colleges said their members have ‘shared concerns [...] over a lack of common standards and expectations’.

Similarly, the Muslim Doctors Association commented that ‘...the role of independent medical expert evidence is unclear and needs to be more specific. In our experience there is very limited use of a true independent medical expert.’

**Independence, conflicts of interest, and bias**

As we have seen in recurrent themes identified in responses to previous questions there are issues with perceived/actual lack of independence and/or a presence of, or risk of bias by ‘experts’ who are selected. The Association of Surgeons of UK & Ireland said that ‘...Truly independent (i.e. external) medical expert evidence almost never forms part of the process of local investigation.’

One respondent says they have ‘...experience of at least one Trust disregarding the opinion of an independent expert and seeking another one as it appeared not to suit a preconceived view of the incident.’

The BMA and Doctors Association UK both echoed this concern regarding a lack of ‘true’ independence in local investigations, saying that the ‘the medical expert is often already part of the team, employed by the healthcare organisation.... [which] can create a conflict of interest.’ They (and others, including the Royal College of Physicians) recommend that ‘the medical expert commissioned to carry out the investigation is truly independent of the healthcare organisation of the doctor being investigated/not employed by the healthcare provider, or if independence is called into question by any party, then they ‘...should be able to call for a mutually agreed external independent medical expert.’
Medical professionals, patients and relatives responding say that they doubt the independence of a medical expert if they have been hired by the hospital, Trust or Health Board. They add that ‘Independent Medical Examiners will be employed by the Hospital [so] they could struggle to gain credibility and the trust of grieving families. One suggestion is for families to [be] provided with independent help from e.g. a charity like AVMA’

**Variable approaches**

The NMC told us that in their ‘...experience has shown that the quality of investigations into serious clinical incidents within healthcare settings varies widely’ due to the different approaches taken by different healthcare organisations.

NHS England (NHSE) advise that the Performance Advisory Group appoint ‘subject matter experts’ but they recognise that there is ‘local variation.’ in primary care, general practice or commissioning, NHSE clinical advisers may be regarded as independent clinical experts. They add that they have ‘recruited suitable specialists where primary care expertise is not sufficient.’ However they do not tell us how they are recruited or what their role is specifically.

NHS Providers stated ‘...Trusts take a range of approaches to local investigations, which are influenced by the capacity of local staff, investigative skills, clinical expertise, and nature of the incident to be investigated.’

MDDUS advised that ‘...independent medical expert evidence is extremely important in any investigations involving complex or specialist medicine’.

NHS Education Scotland said that independent medical experts are ‘...only very occasionally used to provide independent subject matter experts in high profile or controversial cases.’ One family member respondent said that use of independent medical experts ‘only occurs if there are several deaths and is usually an outside agency such as CQC’.

Some participants felt that an independent medical expert was not warranted unless the matter was severe– there were a variety of interpretations of what severity meant (for example ‘in episodes of severe or catastrophic harm’), and most of the time it was not specified. Most commonly severity referred to multiple deaths or severe and avoidable harm, but some mentioned all deaths should be investigated by an independent medical expert.

**Contextual and realistic view of practice: counsel of perfection – idealism versus realism**

Several respondents indicated that the expert was there as a learning exercise to demonstrate what would be best practice, but others disagreed and felt that the expert should only focus on areas where the practice was unacceptable. One lawyer mentioned that they commission reports ‘from a clinician within a neighbouring Trust for the purpose of identifying errors and learning’.

Respondents often expressed frustration at an unrealistic approach from independent medical experts. Responses indicated that an independent medical expert tended to be overly critical when best practice was not achieved as opposed to realistic or acceptable
practice. Additionally there was criticism of hindsight when the doctor under investigation had to act in the moment with the resources and information available.

- ‘It is easy for an expert to criticise a junior doctor when that expert has all the information and hindsight.’
- ‘The independent expert is not challenged on use of retrospective analysis’

The Academy of Medical Royal Colleges held a meeting to discuss the concerns of Colleges in this area. They found that one of the most important parts of the independent expert’s role was being ‘appropriately up to speed with current practice and, importantly the context of the clinical practice’. The Royal College of General Practitioners agreed that independent medical experts must ‘fully consider the circumstances in which medical professionals are operating’.

The MPS say they ‘...require competent and credible doctors who can present balanced evidence in the context of delivering healthcare in a modern day NHS.’

The MDDUS agree with this focus on realism and say experts should ‘...apply the standard of care that could reasonably have been expected of a treating clinician (particularly recognising that a clinician should be judged against a reasonable and responsible body of their peers rather than applying a gold standard).’

**Recent experience in clinical settings at the same level/role**

Many responses indicated that the expert’s role was to compare the doctor being investigated to what is expected of doctors at the same level of experience and training. As a result the expert must have recent clinical experience, and ideally this should be in the same setting. Most responses indicated that independent medical experts were more likely to be retired from clinical work and this was unhelpful:

- ‘...the role of "medical experts" may be inappropriate at times. A professor working in a large teaching hospital would have a very different viewpoint from that of a GP working in a deprived area (for instance)’
- ‘...independent medical experts are often retired or older doctors who have limited experience of current working conditions, expectations and stresses - the human factors.’

**Blame**

Many medical professionals felt that the only reason to involve an independent expert at local level was to ‘find fault,’ ‘apportion blame’, or shift blame from an employer onto an individual and ‘not look at a system.’ Dr Jenny Vaughan stressed the importance of a ‘no blame approach and [that] the investigators aren’t influenced by the hospital to find them less culpable.’ And adds that in her view ‘...when BMI healthcare investigated the death of Mr Hughes in 2010 their "independent investigator" ...failed to appreciate the systems errors. A mere 2 years later he became a medical director at BMI.’

Conversely, a couple of patient or family members viewed the role of medical expert evidence as a way to ‘cover up NHS wrongdoings!’, to discourage further investigation or complaint. One family member claims they were told that experts had reviewed their deceased relative but later found this was not the case, saying ‘...One consultant told me he asked for 2 heart specialists’ advice to ascertain cause of death I felt pressured to accept...’
this and believed this consultant so I decided not to push for [post-mortem]. He lied he made it up to stop me having a post-mortem.’

**System failures and human factors**

Respondents indicated that the independent medical expert should ideally evaluate the working environment and system that a doctor is working in, rather than viewing their actions in isolation. Their responses indicated that they do not feel medical experts do currently take system and environment into account.

The Royal College of General Practitioners, Royal College of Physicians and Royal College of Anaesthetists all recommend that expert witnesses need to take ‘systemic failures and human factors, alongside issues around clinical competence’ into account during investigations, whether the investigation is at local level or at a legal/coronial level.

Both the GMC and NMC also agree that a focus on a ‘human factors’ approach to investigations into clinical incidents’ is important for the future; this is perhaps signalling a shift away from the medical record review approach often taken by an independent medical expert.

A Health Board also mentioned that independent experts have to be ‘non-threatening so encouraging open learning’ indicating that organisations may feel defensive about the involvement of an independent or “outside” medical expert.

**Legal/Adversarial**

The Royal College of General Practitioners said that ‘...The role of the medical expert witness is limited by the questions they are asked in court by legal parties who have their own agendas.’

Overwhelmingly the responses from medical professionals indicated that independent medical experts only get involved when they are ‘being sued’ and/or the case is going to court in order to defend the position of a Trust or Health Board.

The involvement of an independent medical expert signalled an adversarial and often litigious process, usually between doctors and families and occasionally between doctors and employers.

- ‘Medical experts are called by either 'side' and present their expertness accordingly. It is not objective. It does not seek to find the truth.’
- ‘I would encourage my MDO to seek it if I felt we might be railroaded by the [Health Board] or the claimants were making unsupportable assumptions or accusations of causation.’

**Conflict resolution**

Linked to the above, an independent medical expert was cited as the person who could resolve conflicts between relatives and clinicians. An outside view is helpful to provide resolution or mediation and subsequently reduce the chance of a negligence claim against the Trust or Health Board.
One family member of a patient says use of independent medical experts is ‘...to provide families with an independent opinion when they and the trust do not agree on the findings of an investigation’

The Association of Surgeons of UK and Ireland said ‘...Occasionally, where the findings of a local investigation are challenged by the family of a deceased patient, the responsible Medical Director of a Trust may appoint an external medical expert both to independently review the incident and to comment upon the local investigation.'

**Providing evidence as a professional duty**

Peer review and ‘being prepared to comment on the actions of one’s peers’ was cited by the Medical Protection Society as a key skill for all doctors and ‘should be seen as an essential component in the role of all established doctors, much in the same way as being involved in other non-clinical duties such as teaching and audits.’

**Importance of lay member involvement in serious clinical incident investigations**

The CQC indicated that investigations should centre the views of laypeople (‘service users’) instead of the views of clinicians, recommending that investigations are chaired by appropriately trained ‘patient representatives’ in order to gain trust and cooperation from patients. Similar to the responses from the GMC and NMC, this indicates a shift away from only using medical expertise.

**Desire for an expert to be a layperson or non-medical**

Patients and relatives indicate that having a medical expert involved takes attention away from the events as they unfolded and instead focuses attention on the technicalities and differences of medical opinion. Some query ‘...Why should an independent person have to be medical? Is that not a root cause of many issues?’

**Awareness of guidance and best practice**

One relative said that the senior doctor investigating their family member’s death was unaware of the guidance on when to institute the Liverpool Care Pathway (which was a key part of their complaint). This made the relative doubt the knowledge of both the ‘expert’ and the consultant in charge of their family member’s care:

‘Dr [named] admission that he did not know the criteria for commencing a patient on the LCP is bad enough, but his suspicion that other consultants in [a named Health Board] were just as ignorant is astonishing. Was [their family member’s] consultant one of those unaware of these criteria?’
Question 23. How are independent experts selected, instructed and their opinions used? Is access to appropriate expertise always available? Do they have training in unconscious bias?

There were 428 responses to this question online and a further 22 offline.

- Professional representative organisation, college or trade union (20 responses: 7 online, 13 written)
- Defence organisation (2 written responses)
- Professional regulator (3 responses: 2 written, 1 online)
- Systems regulator (1 online response)
- Medical profession (367 responses: 365 online, 2 written)
- Patient or family member of a patient (17 responses: 2 written, 15 online)
- Academic (6 online responses)
- Voluntary organisation/Charity (3 online responses)
- Other (3 online responses)

NB: Some respondents indicated that they answered this in the question before this one about the role of independent medical expert evidence (ie Q22). There are also a number of recurrent themes in the responses to this question and indeed some crossover in the analysis.

In terms of ‘access to appropriate expertise’ – online responses indicated:

- Nine said ‘yes’
- 44 said ‘no’
- 359 said don’t know or another response

Of the ‘Yes’ answers, 8 were medical professionals and 1 was from the family of a patient.

Of the ‘No’ answers, 39 were from medical professionals, 2 were from patients and family members, 1 was from a professional representative, 1 was from another healthcare professional, and 1 was from a voluntary organisation.

In terms of whether experts have training in unconscious bias – online responses indicated:

- Three said ‘yes’
- 53 said ‘no’
- 355 said ‘don’t know’ or another response

All of the ‘Yes’ responses came from medical professionals.

Of the ‘No’ responses, 50 were from medical professionals, 1 from a professional representative, 1 from a voluntary organisation and 1 from a patient.

Unconscious bias

Some respondents would expect that experts who are currently working in the NHS will have had unconscious bias training as part of Equality and Diversity training through their employment but as the Royal College of Anaesthetists points out ‘...nevertheless it would be beneficial for this training to be included as part of a bespoke training package for independent experts, and to be taught in the specific context of investigations following a serious incident.’
Most respondents who addressed this part of the question thought that experts probably did not have unconscious bias training and some said that this was a cause for concern (including the Association of Surgeons in Training).

Whilst not all medical professionals gave a yes/no answer regarding unconscious bias training, many felt it was very important for experts to have it, saying that ‘...unconscious bias training is vital and not done often or well enough.’

On the other hand, a portion of respondents felt that unconscious bias training was not particularly helpful because by nature everyone has biases and training cannot eradicate them. For clinicians who had the training as part of an employee induction, they felt it was a box-ticking exercise:

- ‘I have had training in unconscious bias but this is window dressing,’
- ‘I don’t know. But everyone has some unconscious bias, we are products of our environment.’

A small number of respondents felt that unconscious bias is about ensuring political correctness and (seemingly) disagreed with the concept of training in unconscious bias, saying for example:

‘Here we go again ....living in a blue sky bubble.....everyone has bias ....the GMC has bias ..Terence Stephenson has bias and Charlie Massey certainly has bias.. the question is not about bias it is about truth....honest professional options...no amount of pc fluff should get in the way of the truth....’

Interestingly, one person who responded as a ‘regional BMA representative’ and ‘a retired doctor’ working as an independent medical expert claimed that while there is probably no training about bias, ‘only experts to the courts need to be unbiased.’

Some respondents mentioned racism in connection to unconscious bias, and suggested that (‘too many’) independent medical experts were likely to be ‘white middle-aged men’ but said that it ‘should also include women and people from ethnic minorities.’

**How are medical experts selected: recommendations or word of mouth**

We have been told by a number of respondents that there is no formal process of selection of experts and that they are ‘chosen’ on an ‘ad-hoc’ basis, and ‘word of mouth’/recommendations from senior clinicians, executives and lawyers were mentioned as the most common method for finding an expert. This may result in a situation where an expert is instructed simply because they have good connections and are unlikely to be ‘independent’. The Royal College of Pathologists highlight that ‘...experts tend to be chosen because they are known to one of the internal investigation team. Therefore they are not entirely independent.’

One respondent – a retired doctor and medical educator – said that in her experience local investigations involve an expert who holds a position in a Royal College, but these well regarded experts are not immediately available to local investigations:

‘Independent experts are often acknowledged in their specialty and Fellows or other roles in their Royal College or Society. They should have interviewing, mediation and unconscious
bias training. They may not be available to drop everything and travel to undertake an investigation.’

We were also told that the lack of consistency regarding selection and instruction feeds into the variable quality of expert evidence and increases the risk of conflicts of interest.

Responses from medical directors indicate that there are varying approaches to how they select medical experts:

- ‘I would defer to the legal services department/Head of Patient Safety over this question’ – Clinical Director
- ‘I ask the family who they want me to go to’ – Medical Director
- ‘This is usually done by contacting the MD of adjacent Trusts and seeking nomination of suitably qualified independent experts. They are supported internally by the central risk team.’ – Medical Director
- We have a few retired consultants who can be asked, or we ask neighbouring trusts to suggest someone to sit on our panels. – Medical Director
- If it is an independent expert within the wider organisation this is decided by board level clinicians. If it is an outside independent expert this would be through the legal department and I am unsure how they would be selected. – Medical Director

**Access to appropriate expertise**

NHS Providers said that ‘not all investigations are conducted with the requisite skill and expertise’, mainly due to a reliance on available local staff to act as “independent” experts. The Association of Surgeons of UK & Ireland agreed and said ‘access to appropriate expertise may not always readily be available.’

The MDU are concerned that in their experience, local investigations often use clinicians ‘from a completely different specialty’ to the doctor being investigated and this inevitably affects the ‘quality and accuracy of the report provided.’

Several respondents indicated that they had been involved in cases where an inappropriate expert was selected, perhaps due to a lack of medical knowledge among those instructing the experts. For example a respondent says ‘...Experts chosen e.g. by Ombudsman don’t always seem to be appropriate match for investigation e.g. neonatologist for a safeguarding problem.’

Sometimes the expert was considered too specialist – i.e. the expert had focused on a very niche area and this meant that the wider view of those working in the field was lost, ‘particularly on ED [Emergency Department] cases and I suspect on GP cases also.’

Conversely, sometimes there were no experts with knowledge of rare conditions:

‘Access to appropriate expertise is not always available, especially when a patient had a rare condition.’

Many mentioned that anyone can call themselves an expert:

- ‘Essentially you are an expert because you say you are, which is not good enough’
- ‘Solicitors can instruct anyone who calls themselves an expert and in the field of child protection I have seen some quite substandard reports from people...’
less qualified and experienced than me who are promoting themselves as 'expert' witnesses.’

**Variable quality**

As was identified in analysis of previous responses, the variable quality and inconsistencies between medical expert evidence from different experts was again raised as an issue by a number of respondents (including for example, The Faculty of Intensive Care Medicine & the Intensive Care Society).

Both the GMC and NMC have noticed the variable quality of local investigations and the wide range of approaches taken regarding independent experts:

‘We understand from the experience of our Employer Liaison Service that the use of ‘independent expert evidence’ is very varied across providers’ – GMC

‘Our experience has shown that the quality of investigations into serious clinical incidents within healthcare settings varies widely. […] We also recognise the value of professionalising and standardising investigations and think that this will reduce the variability of quality which we see at present.’ – NMC

The MPS also believe that the role of an independent medical expert needs to be given more importance by the NHS and this would subsequently improve the knowledge and experience available at local investigation level:

‘Acquiring the skillset to be an expert witness should be included in the training of consultants and GPs. NHS employers could take steps to make it easier for doctors to be relieved from their clinical duties so they can act as expert witnesses.’

The Academy of Medical Royal Colleges expressed concerns in 2015 about the ‘quality and training of expert witnesses’ but after consultation with their members stated:

‘Whilst there were common concerns [among Colleges] about the variation in the quality of expert witnesses there was a clear agreement that Colleges did not wish to become involved in regulating, vetting or registering expert witnesses’.

The Academy held another meeting on this issue in late 2017, but the response was largely the same:

‘It was agreed, however, to facilitate a meeting with the Coroner’s service, Ministry of Justice and other stakeholders about improving standards of expert witnesses. […] There were shared concerns over the standards of expert witnesses in some cases and over a lack of common standards and expectations […] There was again no enthusiasm from organisations to establish or run any register of expert witnesses as it was felt that the process would be too complex and difficult.’

This response suggests that the problem is widely recognised but the scale of the problem and the task of regulation is something they consider outside of their remit or capabilities.

**Spectrum of opinion**

The Academy pointed out how many different opinions exist among medical professionals and the need to establish what the most commonly accepted view is:
'it is obviously extremely difficult to know where an individual “expert” sits on the spectrum of clinical views and the extent to which that opinion reflects mainstream or established clinical opinion. To that extent there may be a role that Colleges can play in helping provide that assurance.’

**Need for standardised training or guidance**

As we have heard in responses to previous questions the Royal College of Physicians highlighted the need for a standardised ‘agreed’ process of selection and training to establish and maintain independence and that ‘...they should receive training in certain areas, such as unconscious bias and human factors.’ The Royal College of Physicians and Surgeons of Glasgow agreed that ‘...training and experience is important to maintain the trust of all parties.’

Interestingly, NHS Improvement felt that ‘...Royal Colleges would be able to provide information about the training of experts that support investigations,’ however we were told that previously the Academy of Medical Royal Colleges and other stakeholders were working on a guidance document for medical experts and those instructing them, but after the Coroner’s Service pulled out it was discontinued:

‘It was agreed that there would be value in producing a short easily comprehensible guidance document endorsed by a range of organisations setting out the expectations on doctors appearing as expert witnesses and as a guide for those commissioning medical experts. The document would be both for individual doctors and for organisations commissioning witnesses. Unfortunately [...] the work did not progress.’

**Awareness of current and relevant practice**

The Royal College of Paediatrics and Child Health ‘...wish to be reassured that independent medical experts are operating in their field of competence - so that, for instance, they are aware of current practice.’

The Royal College of Physicians stated that experts ‘must be experienced in relevant clinical practice’ and the Association of Surgeons in Training said ‘...there is concern that medical experts are not always currently practising.’

The Academy of Medical Royal Colleges indicated the importance of an expert still being registered with a licence to practise and the Royal College of Physicians agreed that experts ‘...must be [...] GMC registered with a license to practice’ in order for their opinions to be valid.

**Appraisals and GMC guidance**

The Royal College of Paediatrics and Child Health suggested that the GMC should produce additional guidelines for medical experts regarding appraisal. They say that:

'standards could be safeguarded by advice from the GMC suggesting how appraisal for medical experts should occur, and the type of evidence they need to be able to provide to ensure they remain qualified as experts, remain within their field of expertise and demonstrate reflection on any potential bias.'
DAUK agreed with the RCPCH, and added that the GMC should liaise with the Medical Royal Colleges and ‘call for clarity on the appraisal process of medical expert witnesses from the GMC and Medical Royal Colleges.’

**Blame**

As was identified as a recurrent theme in previous responses and in particular in answers to the question on the role of independent medical expert evidence (Q22), a section of respondents felt that the only reason an expert would be approached at local level was to apportion blame to an individual and shift liability away from the employer, saying for example ‘...They are hired guns paid to destroy careers of colleagues.’

**Conflicts of interest and bias**

We were told (again) that because most local investigations use their own staff as ‘independent medical experts’, several respondents highlighted the risk of undeclared conflicts of interest and bias. British International Doctors’ Association (BIDA) said ‘...there is a ‘conflict of interest’ for the management – Chief Executive, Medical Directors and Human Resources Directorates, to influence the internal investigation.’

The MDU are also concerned by a lack of due diligence at local investigation level, ‘...with some local experts is there an obvious conflict of interest with the clinician under scrutiny [...] but that does not seem to be any bar to their providing an opinion.’ They state that when they have been asked for advice from their members regarding a local investigation, they frequently have reasons to question the selection of the local ‘expert’.

**All medical experts are biased against patients**

As we have seen in response to previous responses, a recurrent theme was that several patients expressed the view that all doctors will protect colleagues or their employer instead of protecting patients, and therefore there are no unbiased medical experts.

- ‘No. Independent experts are usually Doctors in the field who will close ranks to protect the organisation/another Doctor and give the slant the Trust wants.’
- ‘The current system does not work. There are very few experts in my experience. The expert doctors and nurses took blood repeatedly from me following a diagnosis of anaemia without treating the anaemia leaving me lying exhausted as a teenager. Medical experts are biased full stop.’
- ‘If in PHSO setting unfair totally biased and cannot trust’

**Unclear instructions and lack of guidance**

Perhaps due to the variable quality and lack of standardised processes generally at local investigation level, the MDU state that medical experts do not have clear instructions on what is expected from them:

‘...whereas a doctor who acts as an expert in civil claims is given clear guidance by the courts as to what they expect of doctors giving opinion and evidence, we see little to
suggest that there are many experts used in local investigations who are instructed in the same careful and consistent way.’

**Commercial agencies and registers of experts**

Many respondents expressed concern about the use of commercial registers or agencies to instruct medical experts. Commercial agencies and registers rely heavily on the experts’ own declarations and often provide court and report writing training for a fee, meaning they have less incentive to thoroughly vet the experts on their books:

- ‘Some Health Authorities depend on an Agency to find an expert and agencies can vary in the quality of experts’
- ‘Agencies seem to have their motives and are biased’
- ‘Solicitors can instruct anyone who calls themselves an expert’
- ‘Experts are generally selected from lists assembled by firms on payment, by the expert, of a fee whose value determines the level of exposure to solicitors seeking to brief an expert.’

**Private healthcare – selection of experts**

Dr Jenny Vaughan is particularly concerned about the lack of oversight in the private healthcare industry and the fairness of their selection processes:

‘As to selection, I have particular concerns about the way in which private healthcare providers select the experts to do their SUIs and I don’t believe that it is a fair or independent process. This should be looked at by the panel.’

**Spectrum of clinical opinion**

Again, some doctors pointed out how many different medical opinions can exist on a spectrum and that all may be valid, saying ‘...expert opinion is just that, an opinion and experts do disagree!’

Because of the range of clinical opinions, this means that Medical Directors or other senior staff can have their own view on what the ‘right’ opinion is and try to find an expert who agrees with them. Several noted this problem:

- ‘Often the expert is selected for a particular opinion rather than a comparative viewpoint.’
- ‘Even if the medical expert is seemingly independent, often they are selected to support a predetermined view’

Furthermore, one respondent noted how an independent expert expressing what appeared to be an uncommon view led to an investigation which was in their opinion unjustified.

‘A friend of mine was subjected to an investigation due to an independent expert making wild claims about her practice and the consequences. It was very apparent to everyone else that this doctor was a minority opinion at best.’

**Local availability**
Several responses indicated that they relied heavily on neighbouring Trusts or Health Boards to provide the expertise they needed for an investigation, and they would have to cope with who was available rather than always having the appropriate expertise. When someone was ‘respected’ this weighed in favour of asking them but may indicate a conflict of interest which was not declared:

- ‘I think people are contacted until someone agrees to do it’
- ‘Based on availability, willingness by neighbouring trust to undertake’
- ‘Whoever is available and respected!’
- ‘Usually if we want one it is a respected colleague from another Scottish board’

**Recent clinical experience in same environment**

As was identified in answers to the question on the role of independent medical expert evidence, respondents stressed the importance of recent experience working in the same environment as the clinician/s under investigation:

- ‘They should all have fixed terms and be within 5 years of active clinical NHS practice’
- ‘Professors from Teaching Hospitals or retired people who have not been in practice in an equivalent unit recently may have no idea what is the norm in a remote hospital or GP practice.’

**GMC experts**

Despite this question being aimed at use of medical experts in local investigations, two responses from family members mentioned the medical expert instructed by the GMC as part of a complaint. Generally these respondents felt that the GMC instructed a medical expert to justify dismissing the complaint. One person simply said ‘the GMC selects experts who will say what they want. Often the most unsuitable ones.’

One respondent felt that the GMC should have chosen a different expert because the person instructed had admitted that they did not have much experience regarding Power of Attorney and related issues:

‘The ‘expert’ who investigated my complaint on behalf of the GMC, after admitting that he/she had little knowledge and experience in this area: an ‘expert’ without expertise: concluded that: “As the clinical team were unaware that the complainant held a Power of Consent for Patient A, there was no need to obtain his formal permission before commencing the LCP.” […] In their dismissal of my complaint, […] the GMC relied once more on the opinion of their ‘expert’, who concluded that communication: “was above that expected of a consultant practicing medicine in the UK.”’

**Access to appropriate expertise**

One family member mentioned that several experts have been involved in the local investigation into their family member’s death. One expert was chosen because of their specialist knowledge and the second was chosen for similarity to the clinician under investigation:

‘In our case two independent opinions were sought, the first for his expertise in neurology, he was respectfully disagreed with by the trust. The second was selected because he holds a similar job role to the consultant being investigated, […] We are also awaiting an
amended report by the trust into the care received from a consultant in the months leading up to our son’s death, due to our severe criticisms of the first edition.’
Question 24. Are there quality assurance processes for expert evidence at this stage, if so, what are they?

There were 405 responses to this question online.

- Nine respondents said ‘yes’
- 104 said ‘no’
- 234 said ‘Unsure, Unknown or Do not know’
- 48 gave other answers

NB: Some respondents indicated that they had answered similarly questions previously– as a result there will be some crossover between these questions.

The vast majority of respondents simply said there were no quality assurance processes; the other most common responses were unsure/cannot comment.

Variable quality and lack of consistent standards

Similar to previous answers to questions about medical experts, most respondents noted the wide ranging differences between experts:

Royal College of Obstetricians and Gynaecologists say that ‘...The variable quality of medical experts has been problematic for a long time.’

The Royal College of Anaesthetists stated that independent medical experts can be crucial for local investigations; however ‘...QA standards for these roles need to be made consistent’.

Commercial competition

Some respondents mentioned commercial competition between experts as a form of quality control, but doubted the effectiveness of it:

The Faculty of Pharmaceutical Physicians says ‘...The on-line sites for seeking experts describe the procedures for allowing people onto their register. There are [a] large number of such registries to allow competition to generate quality but it is difficult to see what their quality control is.’

The BMA add that ‘...Expert witnesses are subject to the market, in that if they are 'bad' they do not get re-instructed, however 'bad' in medical eyes, may not be 'bad' in the eyes of the purchaser.'

Legal recommendation

Similar to commercial competition, most respondents in this category mentioned that the only way to assure the quality of an expert was through recommendations from solicitors who focus on whether the expert helped to obtain the desired legal result when the case goes to court.

Royal College of Anaesthetists advises that ‘...often the quality of experts is established through word of mouth between solicitors, and based on who can argue a case more persuasively, rather than being based on clinical knowledge.’
The Medical Director of NHS Education Scotland commented:

‘In civil cases, solicitors provide this quality control for both sides of a dispute. In criminal cases, the Defence Organisations do this. However [...] we would note that there have been calls for some form of quality control or accreditation for this important role if a case reaches regulatory or judicial proceedings.’

He provided a link to an academic paper on the subject which may be of interest.  

**Training**

The Royal College of Obstetricians and Gynaecologists agreed with the Academy of Medical Royal Colleges that the most effective way to provide quality assurance was to improve and standardise training:

‘The RCOG has previously offered Expert Witness training courses to members in order to ensure they had the right skills, this included training in expert report writing and court room skills.

[...] RCOG fully supports the work the Academy of Medical Royal Colleges is taking forward to promote and deliver high standards and training for healthcare professionals providing an expert opinion or appearing as expert witnesses.’

The Royal College of Anaesthetists agreed and said ‘We welcome the Williams Review’s recommendation for the Academy of Royal Colleges to lead on the setting of standards and training for healthcare professionals providing expert opinion’

**Revalidation and appraisal**

Similar to answers in the responses to the question before this one, some faculties and Royal Colleges relied on appraisal and revalidation:

Faculty of Pharmaceutical Physicians ‘...recommend that medical experts [...] adopt annual appraisal and 5 yearly revalidation.’

Doctors Association UK commented that appraisal and revalidation were ‘...the only quality assurance processes that we know to exist’ but that appraisals need to be focused on the expert role:

‘the appraiser may have the knowledge and expertise to appraise an individual in their clinical role but not have sufficient knowledge and experience to thoroughly comment on their additional role as a medical expert witness.’

NHS Improvement said that independent experts were quality assured:

‘Experts used in this way become part of the investigation team and their contributions are assessed in the same way as any other investigation by the QA process that occurs during and at the conclusion of an investigation (through local assurance processes).’
This response shows that instead of being considered an "outsider", the expert is brought into the organisation for a local investigation. Unfortunately the response does not elaborate on what local assurance processes might involve.

**Medical professionals: 346 responses (1 written, 345 online)**

**None or don’t know**

As seen from the breakdown of responses, the majority of respondents in all categories said there was no quality assurance or they did not know.

One respondent shares their experience of being investigated by the police, the GMC and their employer and says that ‘...the zeal with which colleagues approach the opportunity to individually give their opinion against another colleague is shocking. It is done without a face-to-face discussion or a broader group. It would not pass peer review for a quality journal. It is personal opinion and in its current format should not be allowed.’

**Variable**

Most respondents mentioned that much like the role of the expert, the quality assurance process was variable if it existed at all.

**Yes responses**

Seven of the ‘Yes’ responses came from medical professionals, but the majority of their answers were brief or vague.

Some mentioned committee and board reviews:

- ‘Committee review’
- ‘QA of anonymised reports and meetings/discussions around process and outcome are key to ensuring consistency and impartiality’
- ‘Any expert evidence would be scrutinised by the legal and quality departments and I imagine up to board level’

**Multiple opinions**

Most medical professionals who provided a longer response mentioned the need for more than one expert opinion.

- ‘quality of the evidence is likely to be judged by the case investigator. If it looks poor he or she will seek additional opinions’
- ‘The only way to ensure that you don't make a mistake to have more than one set of opinions.’

Getting more than one expert opinion may not be common according to one respondent who noted that it ‘...gets very time-consuming and expensive’.

There is also a concern that multiple opinions may be sought by a Trust or Health board because of preconceived views and a desire for a particular outcome:
‘There is a tendency if the opinion is not welcome to ask for another opinion.’

**Legal recommendation**

Similar to the professional representative organisation responses, medical professionals who gave longer answers mostly mentioned recommendations from solicitors. Most respondents saw the same problems with this approach in that legal experts find someone who will convincingly argue their “side” of the case and solicitors do not have medical knowledge.

Most of the answers in this category focused on when a case went to court in either civil or criminal matters, rather than staying at the local investigation level.

The Association of Coloproctology of Great Britain and Ireland says ‘...The specialty associations, who have a much clearer idea of an individual’s credentials and qualifications to be an expert witness, feel that the process by which this is done by legal teams up and down the country is inadequate.’

‘This has been a problem in civil cases whereby evidence presented by, say an Orthopaedic surgeon is poor due to being outside of their speciality [Hand surgeon making statements on spinal surgery.] Professors who have not clinically practiced for many years, but are used as "prestige" witnesses.’

A few respondents thought that the legal scrutiny was adequate:

‘Same standard as for court expert witnesses should be applied’

**Patient or family member of a patient (11 online responses)**

**Deaths and cover-ups**

One person replied ‘...It does not look like it given the high funeral rate’ and another said ‘No, it’s a cover up process, just talk.’

**No and don’t know responses**

Most respondents in this category said they did not know (7/11 responses) and a few said there was no quality assurance or did not think there was any.

**Other (2 online responses)**

One respondent for a Scottish Health Board said no quality assurance existed; the other respondent was unable to comment.

**Other healthcare profession (3 online responses)**

One person simply replied ‘Yes’ with no explanation and the other respondents said they did not know.

**Voluntary organisation/charity (3 responses: 1 written, 2 online)**

One respondent said that there should be quality assurance processes for local experts and criminal case expert witnesses. The other respondent focused on expert witnesses at the civil/criminal court and said ‘...this is largely based on their experience and the courts view of that’.
The Medical Schools Council said ‘...Not to our knowledge.’

**Did not know responses**

The following groups all responded with do not know or unable to comment:

- Defence organisation (1 online response)
- Academic (6 online responses)
- Legal profession (4 online responses)
- Medical student (1 online response)
- Professional regulator (1 online response)
Question 25. How can we make sure that lessons are learned from investigations following serious clinical incidents? (please respond here if you haven’t already responded to this question in the patients and families section)

There were 285 responses to this question online.

**Individual responses - Medical Professionals**

Medical professionals provided the highest proportion of responses with the majority being Consultant grade or GPs (there were very few trainee and SAS grade responses). There were no note-worthy location-based trends or breakdowns.

Of these responses, there was a general consensus that learning is not captured well enough beyond a single Trust (and even then, learning and implementation of the lessons/learning is poor). There were several suggestions and themes that arose from the responses:

1. The need for an external independent voice,
2. A learning and no-blame culture,
3. Lack of resourcing,
4. Disseminating findings more widely and in different ways than currently.

**Independent external voice**

The foremost theme that came through was the need for a mandatory, independent, external and centralised investigation body that both investigates and reports findings at a national level. It was felt that external investigators would be unbiased and impartial in the way they conducted their investigation; making it more likely that the recommendations will be implemented by the Trust or Board (who are less likely to implement recommendations made by one of their own employees). They should also re-visit Trusts in regular increments once the investigation is complete. The Trusts should build in regular listening and learning partnerships with this organisation, creating a mandatory and regular reporting process. Several consultants noted that being involved in this process should be a formalised part of training for junior doctors as well as noting that those in non-clinical leadership roles should be regulated by a ‘management’ regulator. There should also be an obligation for senior NHS management to implement recommendations in line with the standards and guidance their regulator puts in place.

Other comments included that it should be a confidential/anonymous process to avoid scapegoating individuals (see comments below), it should follow a defined methodology and be assessed by an external quality assurance body (potentially the CQC or PSA).

**Learning and no-blame culture**

This was a strong theme that came through but there were few practical suggestions of how this would be achieved. Doctors mainly referenced the Bawa-Garba case and stated that not criminalising staff would take away the element of fear that currently exists amongst doctors (particularly trainees). Many suggested that scapegoating creates a
climate of fear and discourages learning from mistakes. Smaller mistakes are often dismissed as insignificant but several of them in a row can lead to situations in which Dr BG found herself in; therefore they should not be ignored. Several doctors noted that a no blame system should be the baseline but only for those who act in good faith with no malice, intent or dishonesty.

It was suggested that until the broader culture within the NHS changes, doctors will continue to be blamed and scapegoated due to the inflexible nature of the system.

New Zealand was cited several times as being a possible model or example of a no-blame system. They approach the industry of clinical negligence from a ‘no fault’ perspective, allowing things to change at a systems level, not an individual one.

**Lack of resourcing/cuts**

Many doctors saw this as a ‘symptom of a broken system’ and questioned how many cuts had been made in the health service that impacted staff time and patient safety. Rota gaps and lack of proper and experience staff were both cited as issues.

They also noted that learning is best captured when Trusts are provided with the resources to do so. When Trusts are stretched they will often trim investigative roles or overload such individuals with too much work leading to rushed and unfair investigations.

One quote that stood out – ‘funding acts as an impediment to change’. It was also felt that a properly resourced system would help the implementation of any recommendations that arose from investigations and allow learning to be absorbed into the daily/weekly learning of staff.

**Disseminating findings widely**

Once the learning is captured at a local level, one of the current impediments to change is the speed at which this learning is disseminated both locally and nationally; this is currently very slow and done in a limited way. The learning also needs to be anonymised to ensure individuals aren’t scapegoated and patients are kept anonymous. Suggestions of how to disseminate this learning are as follows:

- Annual ‘lessons learnt’ newsletter from each regulator,
- Local staff bulletins,
- National reporting tools,
- Regular publication of case examples in journals regularly read by the profession,
- Link all departments that were involved and disseminate in a joint/multi-disciplinary fashion,
- Introduce examples to junior doctors to share learning more widely,
- Make it an additional CPD requirement managed by the royal colleges,
- Convene a panel of respected investigation experts who will share the learning
Overview of organisation responses

These responses largely mirrored those of the medical profession but there were more practical suggestions of changes that could be made. I’ve provided an overview from key stakeholders who responded to this question. Note there may be overlap with question 15 here.

Muslim Doctors Association

‘There are several steps that can be taken to ensure that lessons are learned from investigations following serious clinical incidents:

a) An agreed definition of a serious clinical incident that is standardised across trusts and organisations. This requires close cooperation between local and national systems.

b) Ensuring an open and transparent culture that encourages learning instead of blame; this will encourage incident reporting.

c) Creating an organisation culture that promotes a shared understanding within the organisation that incidents will be handled in a non-punitive manner.

d) Raising awareness amongst clinicians about what should be reported and how, with specific guidelines within a standardised framework.

e) Setting clear policies within the trust/organisations about how reported incidents will be handled, analysed and by whom.

f) Providing guidance and support for staff undergoing a serious clinical incident investigation.

g) Ensuring timely, regular and detailed feedback is given to the clinician at all steps in the process to keep them engaged and informed throughout the investigation process.’

Hospital Consultants and Specialist’s Association

- Investigations by external teams (with legal status and a mechanism for follow up at the Trust in question) and overlap with coroner’s inquests

- Trusts need to be compelled to make the required changes

Health Improvement Scotland

- Referred to the Adverse Events Community of Practice website that was set up to support NHS boards to share learning for improvement following adverse events reviews.

- They aim to widen the scope to sharing learning from other patient safety sources, such as complaints and claims, across both health and social care.

- NHS boards use the learning summary template to share learning about: service improvements following recommendations and actions that have come from reviews with potential national application improvements in the management of adverse events e.g. in
relation to the process of reporting, reviewing and learning from adverse events, and risk awareness notices.

**MDDUS**

- All investigations need to be constructive processes to seek to actively learn from what has happened – and identify practical steps for change

- NOT a blame game where an individual clinician is singled out – MDDUS have seen many investigations like this

- Creation of genuine safe spaces (separate to the Trust, as recommended in the final report of the Joint Committee on the Draft HSSI Bill)

**Association of Surgeons in Training (ASiT)**

- No-blame culture and open approach needs to be taken when serious clinical incidents are investigated. Systems need to be examined and flawed processes identified to allow gaps to be identified and rectified for the future.

- It is well established that errors in medicine are for the most part multifactorial and occur due to defective systems as opposed to negligent doctors.

- 7 key principles to investigating a serious incident were noted: (1): transparency; objective; preventative; collaborative; proportionate; systems based; timely. ASiT believes that a culture change is needed to ensure that these seven principles, which are supported by the Department of Health regulations for the Duty of Candor, are practiced (2).

- ASiT also made reference to the ‘no-fault’ compensatory scheme as adopted by the Department of Health in New Zealand as a good example of how all of these principles can be practiced in real terms

- Legislating for a system of ‘no-fault’ reform has created more equitable access to honest answers and compensation for patients but also novel patient safety data to promote continuous patient safety improvement.

- Clinical Governance and local and national audit meetings should explore the changes and effects of these changes, with a robust audit trail.

**MDU**

MDU felt others are best placed to respond to this but note that some Trusts have introduced a feedback procedure and at the conclusion of serious incident investigations that actively seek the views and comments of participants to help them to understand what worked and what aspects of the procedure might need improvement or change. They suggest this should be considered for wider use.

**RCoA**

- Management and investigation teams must foster an environment of trust and support, by engaging constructively and compassionately with staff involved in clinical incidents and by involving them in the learning process.
Once opportunities for learning are identified there must be agreed and robust methods for sharing these across organisations, including on a national basis when in the interest of wider patient safety.

**Academy of Medical Royal Colleges**
- insufficient attention is paid to developing the skills and competence of those carrying out what is a task requiring specific skills and expertise
- It is essential that reflective learning, openness and transparency operates on an organisational as well as an individual basis following an incident. Emphasis on system reflection as well as individual reflection will reduce this risk by putting the responsibility on the system owners rather than seeking to identify an individual to blame.
- We support the of tools such as the recent Just Culture Guide produced by NHSI building on the work of the Incident Decision Tree which seeks to help identify and differentiate between individual and system issues.

**Association of Surgeons GBI**
- It is important that there is sharing of the results of investigation widely – to the whole clinical team, across directorates and departments at a local level and via regional and national forums, including across and between NHS Boards, with Colleges / Specialty Associations.
- This needs to be undertaken in a “no blame” culture, emphasising learning and development. Where relevant, reviews of change of practice, identification of resource shortfalls and audit of the process should be documented.

**RCPsych Scotland**
- The focus of any review needs to be clear and explicit. Adverse event reviews are not about maximisation of perfection, but rather, at looking what can be learnt.
- Adverse event reviews should be separate from disciplinary processes, as the purposes of these two investigations are different. If a review highlights failings relating to disciplinary reviews, then disciplinary procedures should follow through with these issues – disciplinary outcomes should not be the responsibility of a review.

**RCR**
- Those who have made an error need to be able to reflect and be supported to change their behaviours / access extra training as required.
- The department needs to promote the lessons learned and facilitate a culture shift to embed this change. Highlighting learning points is difficult to do in a “no blame” fashion. Generally, this is meant to be done anonymously, but most staff learn about SUIs on the grapevine (which is often infected with misinformation). The organisation needs to transfer learning across siloed working. If a department has not been party to the error - “this never happens here” - then there is resistance to change.
-Who holds the department or trust to account about implementing the learning outcomes from an SUI? Is it the governance team (not clinical but at board level or equivalent) or is it the CCG who commission the service?

The AoMRC (which provided a general response rather than question by question) emphasised the importance of preventing harm rather than responding to harm: ‘The service should devote its efforts to training, supporting and helping staff avoid errors rather than just investigating past mistakes.’

The Assoc of Surgeons of Great Britain and NI was one of many organisations that highlighted the importance of leadership and organisational culture in ensuring lessons are learned: ‘...a change of culture whereby staff feel they can report mistakes and adverse incidents without fear of retribution.’ It also made some practical suggestions: ‘It is important that there is sharing of the results of investigations widely’. This needed to include the whole of the clinical team, across directorates, departments at a local level and via regional and national forums. ‘Organisational morbidity/clinical governance meetings should have a specific section set aside to consider the learning points resulting from such investigations and signing them off should be the responsibility of the medical director.’

Revalidation should also play a part: all serious incidents in which each clinician has been involved [in whatever capacity] should form ‘part of the supporting documentation for annual appraisal.’ But this must be done in a no-blame culture emphasises learning and development. Stuart Irvine, responding on behalf of NES, also pointed to the M&M meetings and the appraisal process.

CQC picked up similar themes about culture and leadership. It noted that organisations that are well led and have good assurance and governance processes tend to be safe and get outstanding ratings in one or other core services. CQC also made the point that for lessons to be learned, Trusts must take ‘serious incidents seriously’ and not dismiss them as ‘a one off’. These are places where there is an effective safety culture where ‘safety is everyone’s responsibility and everyone is actively involved in learning from patient safety incidents.

DAJ Human Factors Group offered some very helpful remarks which, of course, placed great emphasis on a human factors approach to understanding what went right as well as what went wrong. But again, culture was key: ‘an open reporting culture has been and remains vital in driving safety improvements within the NHS.’ Healthcare workers have to be able to feel able ‘to talk openly and honestly about clinical problems’. This might require a ‘safe reporting area’ as proposed with HSIB. Like the Assoc of Surgeons, DAJ pointed to the importance of local forums for learning from adverse events: morbidity and mortality meetings should be part of the regular work of all departments and time for these should be allocated in job plans.

But RCPath note that learning could be hampered because ‘investigation reports tend not to be circulated for comment or discussed widely enough to allow true learning’. However, MDU noted that some Trusts have feedback procedures at the end of a serious incident investigation.

NHS Providers provided the most detailed response on this question. Like other commentators, they start optimistically by talking about the effects of culture...
leadership: ‘through sustained emphasis is policy and local leadership, the transformation to a learning culture is gaining momentum.’ The first step towards this is ‘to develop a culture of trust where individuals feel confident to speak up...and with a lens on understanding contributory factors surrounding the incident rather than attributing blame.’

NHS Providers listed a range of processes that are used to facilitate learning: Examples are the use of SMART action plans, safety bulletins, recording themes from serious incidents to prioritise for trust-wide learning, monthly board reporting to include SIs declared, SI investigations completed and outcomes. But they acknowledge that the persistence of Never Events suggests that transforming learning into change is less effective. They list the following additional ideas:

- GMC to share details of incidents it is aware of with Trusts
- Training and resources dedicated to building teams of investigators who are skilled in the facets of investigation.
- NHSI publishing Never Event action plans that relate to systems and processes.
- Having a locally centralized model for collating and sharing learning
- Scope for incident review to look outside the Trust to bring local leaders together to solve problems
- NHSI to look at whether root cause analysis remains best practice.
- More feedback to Trusts on NRLS (National Reporting and Learning System) reporting. [This was reiterated by the MDU]

The also identified some inhibitors and further proposals:

- The volume of reporting is inhibiting the quality of reporting
- The tight timescales for completing investigations achieve compliance at the cost of quality.
- The should be better information on incidents provided at board level to enable trends to be identified.
- A stronger move towards human factors analysis is needed. They refer to NHSQB’s Human Factors in Healthcare Concordat.
- Families should be involved in investigation as ‘routine practice’
- NHS should produce guidelines for training staff in how to approach families
- Lessons learned from SI investigations should be shared with colleges and HEE to incorporate in training

A number of the medical royal colleges picked up the theme of culture, trust and supportive enviroments. The RCoA wrote that doctors ‘have to feel about to reflect openly and honestly on their practice without fear that it will be used against them and that management and investigation teams must foster an environment of trust and support.'
Similarly, the RCP wrote that ‘Lessons will only be learned from investigations following serious clinical incidents when the focus shifts from apportioning blame’. RCPsych wrote that ‘Adverse event reviews should be separate from disciplinary processes’.

Again, culture was at the heart the MDDUS response when it wrote of the need to get rid of the ‘blame game’. It argued for genuine safe spaces in investigations ‘allowing a thorough identification of all issues and real learning’.
**Question 26** - **What support is provided for doctors following a serious clinical incident that has resulted in the death of a patient (including emotional, educational, legal, professional support)? Could this be improved? If so, how?**

There were 528 responses to this question online.

- The most common sources of support cited in the responses are: informal (peers, colleagues, family & friends); medical defence unions; MPS; the BMA; educational/clinical supervisors.
- The responses reveal a strong sense that support is lacking and that (emotional support in particular) should be improved.
- Some indication that the level of support available varies by Trust.
- A range of suggestions for improving support are offered. A common theme is that a more systematic approach is needed.

**Examples of support**

The most common examples of support cited are:

- ‘Legal’ support from trust legal team, BMA or MDOs. With the word ‘legal’ being mentioned 98 times (with most of those responses saying this is the type of support available).
- Informal (Peers, colleagues, family and friends)
- Educational/clinical supervisors

Also, some mention of:

- Professional bodies
- GPs
- Local Medical Committee or Performance Advisory Group;
- Occupational Health
- Deanery, including ‘the professional support unit at the deanery to help with communication skills issues, including simulation training and linguistics support for this.’
- Medical Director’s office
- Open door policy with senior clinical leaders
- Schwartz rounds
- Unit psychologists
- Trust counselling service
- Practitioner Health Programme
- Mentors
- HR departments
The Royal Medical Benevolent Fund
Samaritans (and other charities/voluntary organisations)
an "attending coroners court" information DVD though for junior clinicians to view
Learning lessons workshops
If a doctor is excluded from clinical duties some Trusts have a ‘buddy’ system and keep in touch informally to offer moral support
Remediation support is also offered, ‘but because doctors move around so much there’s often little incentive for Trusts to invest in this.’
Some colleges

Extent of support available

The main theme to emerge from responses to this question was that the support available was, at best, variable, and often seriously lacking.

The online responses were analysed for views about the extent of support available. Of the 528 responses considered:

- 235 respondents indicate that no support, or a very limited amount, is available.
- 74 respondents indicate that a variable degree of support is available.
- 7 respondents indicate that a good level of support is available.
- 53 respondents indicate that they don’t know, or are unsure of, what support is available.
- 186 responses do not indicate an overall level of support (ie. responses restricted to providing examples of support available), or they are unclear.

NHS England acknowledged that they ‘believe a duty of care exists to practitioners under performance review, particularly when suspension or removal from the performers list is being considered.’ They say their policy is to ‘signpost’ those practitioners to available support, or if upon risk assessment it is deemed warranted, they will alert the organisations providing support of the ‘risk.’

One medical professional who shares their experience of being investigated for GNM says that the support is ‘...appalling. In the days before the police are activated the practitioner has no awareness of what is to come. As soon as the police are informed the practitioner, if at work is removed. If at home he/she is barred from the hospital premises and any personnel that work at the trust. Staff are told not to have any contact with the doctor by phone or in person at their home. The doctor is told not to discuss the case with the press and staff and the doctor are threatened with action by the trust for any breach. Under these conditions the doctor is totally isolated and criminalised. Predictably the press do get involved and this is stressful when being told that you cannot talk to them. In fact you can talk to them and this is far better than hiding and in fact many people do have contact with the accused and this is massively important for moral. Of course the trust take no action.'
The trust acts as a bully. There can even be pressure on the doctor not to travel because of adverse publicity. Again wrong and has no grounds. However the trust do not want adverse publicity by harm or suicide, which is unfortunately far too common, then the trust step in and ask you to attend occupational therapy. Here at least the attitude is different and supportive.’

Support available for junior doctors vs senior doctors

A number of individuals and organisations, such as the Association of Surgeons of GB and NI, acknowledged that there was deanery level support for trainees but for senior clinicians there is less support available or that the arrangements are variable and ad hoc. One medical professional described that they witnessed very good support (legal and professional from their trust) given to a junior colleague, they say however that they ‘do not think we would have this level of support higher up the organisation.’ They say they are expected to use MDOs instead.

Contrary to the common opinion expressed that trainees are well supported (or at least have better support than their seniors) one respondent told us that ‘As a registrar I was involved in a case where a baby died and the family went to the media which was enormously stressful: and I was given no support or help at all, not even a few words of encouragement from my supervisor. At the same trust we had a maternal death: and there was plenty of legal preparation for the coroner’s court but zero pastoral care.’ This gives an indication that the extent of support from supervisors may be dependent on individual approaches. Similarly, we were told that the local medical committee ‘can be supportive dependent on the personalities involved.’

Another respondent says that following the case of Dr Bawa Garba ‘...There is concern that the doctors in training will not be supported by supervising consultants and that responsibility will not be taken by the employing Trust.’

We also heard that in general practice a respondent thinks that ‘the support given to trainees involved in such incidents is very good. In hospital settings it is very variable and depends largely on the personality of the consultant acting as Clinical Supervisor. Trainees in hospital are often not advised to contact their defence union before writing any submission / response to Ix.’

Lack of and/or variable support

DAUK wrote that there is ‘no formal organisational support for doctors’ and doctors often find it difficult to speak to peers, colleagues, supervisors and managers. They refer to the PHP for doctors in London, but not that this isn’t easily accessible for doctors from elsewhere in the country. They go on to say that educational supervisors should receive training in how to support trainees through serious incidents.

The Royal College of Pathologists said that there is generic support from Occupational Health but ‘this is unlikely to be in depth’.

MSC continued the theme saying there may be no mentorship, senior counsel or psychological support’ but there should be ‘standard guidelines as to what is reasonable for all Trusts.'
Stuart Irvine for NES echoed this theme, describing the situation as ‘variable’, but noted that the position tends to be better where trainees are involved.

The word ‘variable was also used by an individual respondent who said that pastoral care is ‘worryingly absent’ from Trusts.

RCP&S Glasgow said that Trusts and Health Boards ‘often fail to support their staff’. It also complained that the GMC does not support doctors during these difficult periods and that there was a conflict between the GMC’s regulatory and educational/supportive roles.

The RCOG referred to the support that colleges provide but acknowledged that what the college sees is ‘probably the tip the iceberg’.

RCR felt that although most Trusts have confidential employee support available it was often not well publicised.

Defence organisations highlighted the support that they themselves provide but said that ‘the trust seems to close ranks and ‘thrust the doctor into the spotlight unaided’ (MDU). Similarly, the MDDUS expressed concern that doctors who are not members of defence organisations ‘will potentially have very little support’.

NHS Providers struck a more positive note, writing that ‘Trusts advised that they have a range of support services available, though in some organisations this offer is more comprehensive, formalised and well established than in others’. They list a number of the mechanisms of support identified in responses generally listed above. NHS Providers also said that Trusts recognise there is ‘scope for improving the quality of individualised support to staff who are being investigated.’

Also on a positive note, the RCoA referred to the Association of Anaesthetists of GB&I Catastrophes in Anaesthetic Practice – dealing with the aftermath which covers psychological support for staff. They suggest similar guidelines should be available for all specialties.

**Limitations of legal support available**

Whilst legal support was one of the most frequently mentioned a number of respondents mentioning the ‘legal support’ highlight flaws and limitations with it, which the following comments demonstrate:

- ‘Trust legal department is primarily concerned with Trust reputation/legal position, not that of an individual trainee).’
- ‘Different legal firms have different approaches...our current legal advisers who are perhaps more business like and as a consequence "colder" and apparently less insightful regarding the demands made on clinical staff.’
- ‘tends to be swept under carpet by legal team’
- ‘The trust solicitors are, in my experience, terrible at representing the individual Doctor at inquest. They are difficult to contact and lack the resources needed. The
defence organisation solicitors are better but their increasing reliance is pushing up our subscriptions.’

- ‘The trust has a legal department for civil matters (not criminal prosecutions against individual doctors)’
- ‘Legal ‘support’ is more mechanistic than supportive.’
- ‘interviews with trust solicitors - usually not hugely helpful as are very much centred around what the solicitor needs to know, with little description of process and events for junior clinicians’
- ‘doubt would get any support from trust legal’
- ‘Doctors are actively discouraged from bringing a legal representative with them to investigatory meetings’
- ‘The legal support would come from the hospital, who I hear can be terrifying.’
- ‘We were told by the legal team that because there was a risk both the Trust and the individual concerned could be legally pursued by the family, we needed separate legal advice. This placed employer and employee as legal adversaries, meaning sharing information and providing support was not possible. We sought support from the Deanery, and got sold down the river because of a failure of objectivity of the programme director. As a result, three years on, we still have trainees refusing to come here for training rotations siting lack of support in that case as their reason. This cannot be allowed to happen elsewhere, and this is why the current system needs to be reformed. legal considerations and processes are interfering with the nature human desire to comfort and support colleagues.’
- ‘Legal support is from the defence unions and the MDU did not cover themselves in glory with the Bawa case.’
- ‘The MDO’s provide legal support where they are members, trainees often aren’t MDO members.’
- ‘The BMA offers support to those under investigation, but they drop you once they think your legal fees will be high.’ Another says ‘...the BMA is woefully inadequate most of the time.’

A few respondents highlighted that legal support ‘...depends on existing insurance, which does not cover all eventualities.’ Another says ‘...If the doctor has no personal indemnity they are very exposed. Bearing in mind that indemnity usually doesn't cover GMC hearings and only covers court hearings.’ In relation to indemnity cover we are told that ‘...worryingly, in the decades since Crown indemnity was introduced, many junior doctors are under the impression that they have no need of MPS/ MDU membership. However, I have witnessed more than one event where a junior doctor has been found at fault in a serious incident in order for the trust to settle out of court and avoid a costly trial. In one case this led to the doctor leaving hospital medicine.’ This lack of awareness seemed
apparent from a couple responses, for example one respondent tells us they were ‘not aware of this until very recently.’

MDDUS note that the government is set to introduce state-backed indemnity for GPs in April 2019, but this will not, to the best of our knowledge, include assistance with significant event analyses following deaths, inquests, or regulatory or criminal proceedings. We are concerned that a tranche of GPs will be unaware of the significant disparity between the services and support offered by their current MDOs and those available under the future state-backed scheme; and this is likely to lead to a cohort of GPs who may fail to continue membership of a medical defence organisation and will not have ready access to the help and assistance that they need in investigations following deaths.

A couple respondents reflected a more positive experience of ‘legal support’, for example ‘...in primary care we have defence union membership, I have found them very supporting and being able to see things from my perspective.’ And one respondent saying that their ‘Trust provides good legal support, when things go that far.’

**Issues which demonstrate the need for greater support**

A number of respondents draw attention to other issues with and barriers to effective support:

- the persistence of a blame culture and the need to move away from this;
- A few also highlight the treatment of whistleblowers as examples of how medical professionals are not supported (including Stephen Bolsin and Chris Day)
- In relation to the culture in particular specialties which prevents doctors from seeking or accessing support, we are told for example ‘...my husband is a vascular and paediatric surgeon in a large DGH and I think that there is still a strong ethos of stiff upper lip in general surgery.’

We were repeatedly reminded by respondents that:

- To have been involved in the unexpected death of a patient is extremely traumatic and upsetting.
- ‘Such events can cause mental health problems and result in the death of the doctor.’
- Often we don’t even find out the results of investigations into significant events that we were involved in. This means that we don’t get closure on an event that may have been emotionally harrowing for professionals.
- As many investigations take many years to complete and the impact on doctors and their families cannot be underestimated.
- Strong perception that doctors can be left feeling isolated in these circumstances; for example, ‘Most organisations don’t allow the doctor into the hospital which can be extremely distressing; ‘the support is concentrated on the patient and family which increases the feeling of isolation.’

We were also told about other issues with the impact of investigations, such as:
• Doctors do not have access to the medical records or documents which they may need to recall the incident. When documents are provided they are often incomplete, redacted and arrive very late in the day.

• Medical defence unions often advice to say little (as do hospital trusts) - this can escalate things.

• The wording of any correspondence is legalised and adds to the stress burden.

• Respondents also highlight issues with doctors being suspended by their employer – including the disproportionate length of suspension and the emotional, personal and professional impact - The longer a doctor stays out of practice the harder it is to re-integrate them in clinical work (one example given was ‘the Jo Jordan case - obstetric reg where there were allegations of bad forceps delivery - his appointment to consultant was delayed, and all knew his competence was questioned, despite his being vindicated as I understand it.’

• Some respondents suggest that doctors require more protection from the media following serious clinical incidents (an example given was ‘the baby P case at GOSH and the paediatrician and the GP who was caught up in the process).

• ‘If a trainee is in a trust post, the space, support and time to reflect on such incidents is much less than in GP. Even if the trainee wasn’t at fault in any way shape of form, reflections about the incident and impact upon team are invaluable.’

Impact of investigations on doctors’ mental health and the suicide rate amongst doctors who are investigated

Anonymised diary entries, (documented by a doctor in the first three months of being investigated for GNM, before the case was closed with no further action) provided by a doctor’s defence organisation, demonstrates the detrimental impact that the investigation was having on their mental health and wellbeing:

‘I’m now crying inconsolably and quite frankly feel like walking under the nearest bus.’

‘I visited the GP. He has given me 6 weeks off and prescribed some sleeping tablets as I haven’t slept for a few nights now.’

‘My health has been irreversibly affected by this investigation. In the space of a year I have gone from a fairly normal person of my age with the usual grumbles and worries of life to a person with chronic severe anxiety and a need for antidepressant medication. I still have regular insomnia, anxiety dreams and nocturnal panic attacks... not sure if or when this will ever change.’
A number of other responses highlight the higher than average suicide rate amongst doctors facing fitness to practise (and other investigation) proceedings and strong views about this, as well as a number of criticisms about the GMC (although to note, this question was intended to elicit views about experiences of support during local investigations. Therefore the themes identified here were repeated in responses to the questions about the professional regulatory process Q47-52):

- There has been concern about the suicide rate amongst doctors undergoing Fitness to Practice (FTP) investigations by the GMC. In a footnote to a study published in 2016 it was noted that of 5,728 doctors subjected to investigation by the GMC in 2012 and 2013, 13 committed suicide. This gives a suicide rate of 227/100,000. In the general population at that time, the suicide rate was 11.6/100,000 (ONS, 2014); amongst prisoners, the suicide rate was 65.5/100,000 (DH, 2014; MoJ 2013). The relative risk of dying from suicide whilst under GMC investigation in 2012 was therefore twenty times that of the UK general public. (Suicide whilst under the GMC’s fitness-to-practise investigation: Were they preventable?, Casey D J, Chong K A. Journal of Forensic and legal Medicine 37 (2016) 22e27)

- 'doctors face a lengthy drawn out process of legal proceedings, with little support, often whilst not working and on unpaid leave. Suicide is often the best answer that they see, and sadly lots of junior trainees chose to kill themselves rather than face an unknown period of financial ruin, and destruction of their reputation. Chris Day had his legal team resign just before his case, and his trust disowned him, then HEE denied employing him (despite the court since ruling they do employ trainee doctors). I guess the Samaritans offer support, but that's a bit far down the line. Doctors kill themselves whilst under investigation. They are vilified in the press. Suicide would be the choice I would make rather than lose everything I have worked so hard for get destroyed in the public eye.’

- 'The general view among my medical colleagues is the GMC will pursue you to your destruction either ensuring you end up in prison or you commit suicide. The GMC will deny this but this is the view of my colleagues who feel the evidence of the last 10 years support this. Two of my wife's colleagues who felt they will never get a fair hearing have killed themselves’

- the attitude of the GMC which has seemed to have an approach of 'you are guilty until proved otherwise'

- The GMC has said in the past that 'doctors need resilience training' -- utter rubbish, and utterly insulting. In English law a person is innocent until found guilty, and no-one --NO-ONE -- should be treated the other way round. (And yes, if they are guilty of something really heinous, they should most certainly be punished.) But the psychological torture of being investigated can be severe and the intensity of it should certainly not be underestimated.

- We could do with gutting the UK of its GMC regulation, returning to the courts for a while, perhaps. For a body to have persistently resisted votes of no confidence is one thing, but to have had one for so long that uses 'public confidence' as an Orwellain fallback whenever challenged is beyond contempt. The public are never going to have confidence in doctors if the GMC blames them personally for NHS system failings, even after doctors have let the public know that is what has happened. Mind you, I have equal and utter contempt for the judges and the legal system for the Sellu case, the Juniors’ case over Hunt’s lies in Parliament regarding the strike, and ultimately Elizabeth Windsor’s tenure. Wish I’d emigrated when the family could have managed that.

**Suggestions for how the support available could be improved**
• The introduction of a helpline and mentoring system;
• anyone called to coroner’s court should automatically get counselling.
• Dedicated support teams/services at a Trust or regional level;
• Ability to reflect in confidence without risk of submission as part of legal proceedings;
• Provision of independent support;
• Learning from adverse events / debriefing sessions (with those outside of line management structure);
• Emotional support.
• More occupational health support; A healthcare wide occupational health service, catering for all those who work in any healthcare organisations; including the opportunity to see an occupational psychologist following an unexpected patient death
• Support from peers/colleagues;
• Independent supervisor (removed from the event);
• A local support panel including different medical specialities (eg. primary/secondary care, retired practitioners, lay person);
• Regular updates for doctors under investigation;
• Better communication; ‘Greater coordination of these processes would help, but at the beginning of each investigation, the seriousness of the incident may not be immediately realised and therefore the referrals may often be made later, and in a rather haphazard order’; ‘Having one identified independent support system that may be able to direct doctors to appropriate services may improve outcomes and ensure that unsuspected outcomes are thought about.’
• The people dealing with the investigation should have some experience of human factors training and counselling skills;
• A Trust lead role for support of doctors involved in SUI;
• Automatic legal assistance to doctors by medical indemnity organisations;
• Ability for staff to attend the occupational health service of a Trust not involved in the investigation;
• Educational elements divided into those from which there can be shared learning and education and those which may require individualised additional training or education;
• ‘Buddy’ system;
• Breaks from clinical practice;
• Anonymous helpline;
• Educational support should be part of requirements for appraisal/ revalidation. GMC/royal colleges should take the lead;
• Professional Support Units within deaneries could provide a more active role in supporting trainees. Perhaps it should be mandatory for educational supervisors to refer to a PSU any trainee who is substantially involved in a fatal incident inquiry;
• Medical indemnity organisations do not automatically provide legal assistance to their Doctors - could this be an area for improvement? Another says they ‘think that it should be emphasised to final year medical students that they do still need external defence cover, so that they can be supported legally and financially.’
• Allow whistleblowers anonymity;
• The MDU comment that the new Duty of Candour Procedure (Scotland) Regulations 2018 require trusts to provide staff with details of support available to them and suggest that this is a step in the right direction.
A national support and counselling service for doctors;
• Working with the defence unions to see where gaps in support are greatest;
• Guidelines for every medical specialty that form part of local policies for dealing with the aftermath of serious clinical incidents;
• Expanded use of the Practitioner Health Programme;
• Better promotion of existing support that is available;
• Learning from best practice (Guy’s and St Thomas’ Trust praised by one respondent);
• The introduction of a recognised pathway for personal and professional help and support following significant events;
• There should be specific training and person whose role it is within the trust to ensure trainees are appropriately advised and supported.
• Trainees should be encouraged to reflect upon such issues and this should be able to be included in the documents of training BUT these reflections should not be accessible within court/legal setting. Doing this has put a stop to us expecting trainees to reflect in the ePortfolio whilst a case is still open.
• Educational supervisors should receive regular training on how to support trainees through serious clinical incidents.
• The completion of trainee reflections or joint reflections about serious clinical incidents should be subject to legal privilege.
• The BMA recommends that Assisted Action Plans, which NCAS used to provide to employers and individual doctors during disciplinary proceedings, should be reinstated;
• The GMC should have a role in monitoring safe working conditions or as a minimum be required to review this when investigating a doctor as it is a patient safety issue;
• GMC could improve communication with doctors involved in FtP cases
• Speed up GMC investigation processes; ‘To fulfil timescales for delivering a verdict and answer to a different authority if they broke these timescales without good reason.’
• ‘by making the trust solicitors and the trust responsible for ensuring adequate resources are in place and GMC money should be transferred to the defence organisations. Why should I pay for the GMC when they are there only to sanction me?’
• I think the GMC could play a role here but is not widely trusted to do so
• Learning from the HSE and aviation industry.
Inquiries by a coroner or procurator fiscal

Question 27. How and when are decisions made to refer a fatality to the coroner, or in Scotland, to the police? Who does it? Who do you think should do it?

There were 452 responses to this question online.

This question yielded mainly factual or descriptive answers rather than ideas about how things should be done differently. However, there were mixed views about whether the processes were clear and consistent and well understood. Overall, it was apparent that the reporting system (in England and Wales and possibly Northern Ireland) is not consistently understood by clinicians. The guidelines for reporting patient deaths to the Procurator Fiscal in Scotland appeared to be more widely, clearly and consistently understood by respondents.

Patients or family member experience

The responses from patients and families drew on their personal experience of, or perceptions about, referrals to the coroner, all of which were negative, lacking transparency, communication fairness and/or clarity:

One family member described their experience of the administrators at [the named] Hospital who referred their family member’s death in 2005 to the coroner, ‘because no doctor in the hospital where she had spent the previous two months was prepared to certify the cause of death’.

Another respondent described how they experienced the senior coroner in their area ‘supposedly investigating’ their family member’s death in 2015 for two years to then discontinue the investigation a few days before the pre-inquest hearing (concluding natural cause of death as a result of sepsis). This family member had raised a number of questions on the post-mortem report that they felt were never answered by the coroner. They also claimed that the coroner’s officer had agreed with a hospital doctor to keep the result of a swab from the surgical site off of the death certificate. This respondent felt as though the ‘care’ leading to their family member’s death was not dissimilar to that found by the Gosport Investigation (elderly patients given opioids and suffering from dehydration and non-terminally ill patients being treated as ‘end of life care’) and that there should be an urgent review of other hospitals, such as this one.

One family member says that they had... ‘no idea [who referred the death to the coroner] as when my family requested a post mortem for my mum we were told by the patient liaison officer that we would definitely get one if we explained our concerns and why we wanted one…we had to wait 5 days for the coroner to return to work and then he decided within a few hours after reading only our email that we didn’t need one as he was happy with what the doctor said. He didn’t even speak to us he got his secretary to email us.’

One respondent says that they took the death of a family member who had been put on the Liverpool Care Pathway... ‘through PALS and we were unaware that we could have had a coroner’s inquest, especially as the hospital misled us telling us dad had been ill for 15 years which was untrue. However, regardless of my dad’s case others have been refused a
coroner’s report because the doctor’s report sufficed. In our case we got the entire medical team and an apology for the negligence with what happened to dad as it was a junior doctor who was receiving payments for the number of elderly people he bumped off!’

Again another family member recounts their account of lack of independence in referrals, saying ‘...In my case, the consultant in charge of my mother’s care made the call the day after the death. I do not know whether this is in accordance with the hospital’s policy or not. In my view, a senior member of the executive should undertake this call rather than the perpetrator to ensure objectivity.’

One family member says that the doctors ‘...didn’t [refer to the coroner] in my case. When now, with hindsight they absolutely should have. ‘Natural causes’ was decided without [the] coroner knowing what had happened.’

A few family members left comments about they think ought to happen:

- ‘Families should do it!’ i.e. the referral to the coroner.
- ‘I know that ma[n]y cases that should be referred but aren't!’
- ‘...all avoidable deaths should be reported to the police and coroner by the ward senior consultant if they aren’t there at time of death then manager of ward and tell the truth about the real cause of death not play down the real cause of death covering up negligence.’

**Who does it?**

Respondents that are medical professionals said that referrals can be made by:

- Anyone or anybody involved in the patient's care/healthcare professionals/ward teams/medical team/clinical team/GP/consultant in charge/hospital doctor. They can be at ‘any level.’
- The clinician, with some saying this is done with support by the bereavement team (as well as noting that the clinician has a professional duty to refer to the Coroner).
- Any doctor called upon to complete the Medical Certificate of Cause of Death (MCCD), which is ‘often escalated to the treating consultant’ or ‘the second doctor where there is a cremation also has power to refer on’
- Many respondents commented that a referral is made by a ‘junior doctor’ or ‘the most junior member of the medical team’.
- The Medical Director (MD) (with some respondents saying that the MD would only do this if the death was escalated as an adverse incident.)
- ‘The Chief Executive in consultation with the Medical Director, usually’.
- The next of kin/the family.
- Managers in the trust/senior hospital manager.
- The risk governance team.
• The mortality review panel.
• Medical examiners (Leicestershire and other pilot areas).
• The police (where doctors have not referred the case to the coroner but the police otherwise have – perhaps following complaint from family members).

**Who do you think should do it?**

Whilst a number of respondents indicated that they thought family members/next of kin could refer a death to the coroner, quite a few respondents also indicated that they didn’t think families could refer, or were not sure whether families could refer - but certainly they made it clear that they didn’t know how a family would go about doing it. Many noted that they thought families should be able to refer. Some said for example ‘It might be helpful for there to be a process whereby relatives can refer a death to a coroner, though there would need to by steps in place to ensure coroner services were not overwhelmed.’ However others expressed the view that ‘…the family are too angry and not independent.’

Many medical professional respondents who replied to this part of the question stated that they felt that it currently is, and should continue to be, the doctor/treating clinician/the responsible consultant, and some saying that there is ‘no need to restrict the number of people who can report the death.’ This was partly because they are the most practically placed to do so and because they are the ones with knowledge of the care of the patient (‘doctors are best placed to know whether a death occurred by natural causes or not’).

Others said, it should be peers, ‘a tribunal of peers’ or ‘clinical experts without conflicts of interests/who are independent to the case/the responsible clinician to advise on referrals to the coroner’. Further to this, ‘if there was a local review involving expertise external to the organisation this could assist with the transparency and confidence in actions taken, including referral to the coroner.’

We were also told that ‘...it is important that anyone is able to make a referral to the coroner’s officer. It is important that transparency exists at all times and thus this process should be open to anyone.’

Another said that whilst ‘the consultant in charge is generally the appropriate person to refer to the coroner. There may be times when they decide not to refer but other team members think a referral should be made. In this case there should be a system for raising the issue but I don’t know if this exists and I suspect junior staff would not feel confident enough to use it.’

Similarly a member of the legal profession says ‘...It is always helpful for the doctor making the referral to have information about the death to enable a discussion, but it is not always possible, or appropriate if the individual is potentially involved in an error.’

Muslim Doctors Association (and a few other respondents, including the Association of Anaesthetists) say they ‘...think it would be beneficial that an appropriately senior member of the team makes the referral eg consultant/senior registrar. There are a set of predefined criteria that always warrant a referral to the coroner (eg post operative deaths). Outside of these criteria, the decision to refer is usually taken by a senior clinical member of the team.'
and usually the consultant. The actual referral may fall upon the most junior member of the clinical team who may not fully understand the nuances of the case.’

Another individual respondent adds that ‘...perhaps it would be better to have internal case review before discussion with coroner- it is often a very junior doctor who has this discussion. This shouldn’t be the case- should be registrar or above in my opinion.’ Others call for the Multi-Disciplinary Team to debrief before the referral to the coroner by the junior doctor occurs – ‘to support the doctors.’ Alternatively, another suggests that where there is doubt (by a junior doctor) ‘they should consult with a more senior member of the team... if a referral is being made to the Coroner this ought to be done after conferring with the consultant in charge of the case.’ They also said that...’a good bereavement officer should be able to advise, and in my experience Coroner’s Officers are often very helpful.’

How and when are decisions made to refer a fatality to the coroner (England, Wales and Northern Ireland)?

When are decisions to refer (or not) made?

In response to when decisions are made to refer to the coroner, the vast majority (to this particular part of the question) said that it is when a decision as to whether to sign a death certificate is made (‘death certificate’ was mentioned 53 times), often ‘following a brief discussion with coroner’s officer’ and ‘on the same day as the death where possible’.

We are told that ‘when a patient dies, doctors do not have a statutory duty to establish the fact of death, but do need to certify the medical cause of death. Hospital doctors and GPs are not legally required to refer cases to the Coroner, contrary to what is generally assumed. However, it is good practice to refer to the Coroner, via the Coroner’s Officer...’

Dr Oliver Quick tells us that ‘For the deaths of individuals who have been attended in their last illness by a registered medical practitioner, the practitioner is obliged to sign and transmit to the Registrar of Birth and Deaths a certificate on a prescribed form, stating the cause of death (Births and Deaths Registration Act 1953, s.22(1)). In practice it seems that most Coroners follow a working rule that all deaths occurring within 24 hours of emergency admission ought to be reported. Studies suggest that the reporting system is not consistently understood by clinicians and that there is under reporting of deaths to Coroners. To my mind, this should be done by independent medical examiners25 and for this to command public confidence they should not employed by hospital trusts. The details of the proposed system seems to fall short in this regard.’

MDDUS also argue that ‘the systems might be improved by the introduction of medical examiners... and indeed medical reviewers have already been introduced in Scotland.

25 NB: A national network of medical examiners was recommended by the Shipman, Mid-Staffordshire and Morecambe Bay public inquiries and in October 2017 Lord O’Shaughnessy, Parliamentary Under Secretary of State for Health, announced that a national system of medical examiners will be introduced from April 2019.

This is intended to support appropriate referral to coroners as well as organisational learning and improvement.
Unfortunately, the recommendation that medical examiners be appointed to deal with all deaths including those in hospital and the community have more recently been diluted and the latest recommendation is that a medical examiner would be a Trust employee and would deal only with deaths within the Trust. This gives rise to the potential for an inappropriate bias, and a lost opportunity to deal impartially and appropriately with deaths that are not otherwise reported to the Coroner.’

**How are decisions made to refer a death to the coroner?**

In response to *how* decisions to refer are made - there was significant variation in response to this part of the question from medical professionals. Many said that they ‘don’t know’ or answered on what the case ‘seems to be’, as in, it seems to be ‘mandated’, or what they ‘assume’ happens. Many others said that there are ‘statutory’ or ‘clear’, ‘national’,’ guidelines’ (28 times)/guidance (21 times) and/or rules (19 times)’ on what ‘should be’ referred but many did not say what they were.

The Association of Surgeons of GB&NI for example said that the criteria for referral were ‘well established’. Similarly, the Royal College of Radiologists writes that there are ‘clear guidelines for referring deaths to the coroner’.

The national guidelines\(^26\) (in England and Wales) referred to by respondents says that:

A doctor may report the death to a coroner if the:

- cause of death is unknown
- death was violent or unnatural
- death was sudden and unexplained
- person who died was not visited by a medical practitioner during their final illness (N.B This is not legally defined, but is generally taken to be a doctor who cared for the patient during the last 14 days of their life).
- medical certificate is not available
- person who died was not seen by the doctor who signed the medical certificate within 14 days before death or after they died
- death occurred during an operation or before the person came out of anaesthetic
- medical certificate suggests the death may have been caused by an industrial disease or industrial poisoning

Many respondents listed one or some of the criteria above. Or slight variations on the above, such as ‘unexpected’ (48 times), ‘unexplained’ or ‘suspicious’ deaths (both 18 times), ‘all suicides’ or ‘in cases where diagnosis is unclear, recent interventions have been done, where documented errors have occurred, after a fall or a bleed on medication, and/or a

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\(^{26}\) [https://www.gov.uk/after-a-death/when-a-death-is-reported-to-a-coroner](https://www.gov.uk/after-a-death/when-a-death-is-reported-to-a-coroner)
death may also be reported if there has been a loss of opportunity to give timely treatment and potentially this contributed to the death of the patient’.

Variable approaches by coroner area and issues with process of referral

Many respondents described that whilst there are national guidelines, there is significant local variation in terms of each coroner’s (or coroner area’s) expectations and their ‘guidance’ or ‘protocols’ on what should be referred to them.

Some respondents commented on how referrals work specifically in relation to their provider or coroner area, for example:

‘In London the coroner’s rules are pretty specific and should be applied nationally. Any unexplained or unexpected death should be reported and the axiom being "if in doubt - report".’

Some respondents commented more generally that they thought the process of referral works well, the rules are satisfactory, or commented generally on their experience of the process being adequate.

Another respondent says that their coroners have strict guidelines on referral and expect them to be followed. They say that this has ‘raised the number of referrals which is a good thing for openness’.

We were told by one respondent that ‘...In South Wales we have had good advice from our new coroner about what he wants referred and what he is no longer interested in. If a fatality is thought to be due to a serious medical mishap, this would be a "Serious Incident ("SI), and the Welsh Government get informed by the manager of the directorate concerned. There are conversations about post-mortem examinations, and what to put onto the death certificate, and this means phone calls get made to the coroner's office.’

Others strongly disagreed that the process for referral works well, saying that:

- ‘The coronial system and the associated causes of death certification is deeply and fundamentally flawed’.
- ‘There is great variability between coroners on who they refer on to the GMC or to the crown prosecution service. I think this reflects a lack of training of coroners and much clearer guidelines should be provided for coroners on which cases should be referred on’.
- ‘Those intent on concealing their crimes are unlikely to do so [ie refer the death to a coroner]. I think there should be the opportunity for relatives to request a Post Mortem (PM) if they are unhappy about a death, although in my experience they usually do not want a PM.’
- ‘Often one of the most junior members of the team is required to make the decision and there is frequently pressure not to refer.’
- ‘The decision to refer is made at the time when the death certificate is issued. At this stage, there is every opportunity to cover up mistakes.’ Another adds, ‘Referrals
based on death certification rules result in referrals which are unnecessary and takes up time and resources that could be used for other cases.’

- ‘I have come across cases where I thought perhaps that the organizations processes were significantly contributory towards a death and as such warranted investigation, however upon raising such discussion, being quite firmly directed to toe the company line.’

- ‘In my experience coroners aren’t always keen on deaths being referred to them though- our coroner is actively discouraging "unnecessary" referrals.’

- ‘I have always found medically qualified Coroners to be excellent. Sadly I think the police are entirely unsuited to the task unless requested by HM Coroner.’

- ‘I have concerns that more coroners are now just of a legal background rather than medical backgrounds. We are pushing the process further to a complex and adversarial one.’

- ‘Our coroner in Leicester has behaved in an adversarial way in many cases, and appears to be out of line with most other regions. At one time, she wanted all cases of babies that died referring to her. She currently phones families to ask if they are happy with the care (with variable responses as you might expect when your baby has just died) and uses this to decide about inquests. Inquests often take 18 months. In the Bawa Garba case, she aggressively cross examined an expert she had appointed and when he changed his view under cross examination, she referred to the CPS, who were lobbied by the family.’

- ‘Our local Coroner has changed recently and wants to increase the number of inquests. This had had an impact on clinical time and seems arbitrary.’

- ‘The government have issued instructions that more cases should be referred. It is a political decision.’

- ‘The much-needed changes to death certification that have been consulted on, seem to have been delayed by Brexit.’

- ‘Medical examiner's for deaths was the recommendation of the Shipman report we know it would help but the government has decided not to afford it.’

**Local internal processes/protocols**

Other respondents say that the referral is usually an internal process in certain cases (e.g. death of a detainee/detained mental health patient) or that there are ‘local’ or ‘provider protocols’ (eg a trust or hospital department) for referrals or there is ‘generally loose organizational guidance’. For example, one respondent claims ‘...all potentially avoidable deaths would be declared as a serious incident in my trust and would have an early discussion which would include discussion about if the coroner has been informed.’ Others claim referrals are made:

- ‘Within 24 hours of admission to hospital...It is the deaths that occur beyond that time-line that do not always get referred to the coroner’.
‘Liberally - any recent procedure for example.’

‘Where the cause of death is suspicious, regarded as potentially criminal, or unable to be ascertained.’

**Variation by specialty or type of death**

Some respondents commented on how referrals work specifically in relation to their specialty or general practice. We were told that in some specialties all deaths are referred to the coroner:

- Within anaesthetics, there are clear reasons for referral, any death is pretty much essential to refer.
- *In the ED. All deaths are referred to the coroner. Unless there was a clear end of life plan in place and a death cert can be signed. We refer all deaths even if the MCCD can be completed (i.e. in the case of ruptured AAA cases)*
- In paediatric practice all unexpected deaths are referred to the coroner. A child who dies for example of sepsis some days after presentation may not be automatically referred, although if there was concern about avoidable delays in treatment contributing to death it would be usual to discuss this with the coroner.
- Any inpatient deaths in a mental health trust are referred to the Coroner. Although on respondent was ‘not sure if this includes expected deaths e.g. end of life dementia. Any death of a patient detained under the Mental Health Act is referred. Patients who were recently discharged are referred. I am not sure who does the referral.’

In regards to deaths in primary care there was some variation in responses:

- ‘This seldom affects general practice, because there are strict rules about whether or not we can certify a death without at the very least talking to the coroner’s officer, and a patient who is likely to die is usually already in secondary care or else known to be at risk of dying.’
- ‘As a GP we would refer according to set criteria. When our community frail elderly die GP's take that decision.’
- ‘In general practice any unexpected or suspicious death, uncertain or not a natural cause would be referred.’
- ‘I’m not sure exactly what rules apply to other deaths such as accidents in primary care, but in the whole of my GP career I have never faced such a question.
- One respondent highlights that ‘If there is suspected abuse it goes through child protection procedures.’

**Other suggestions for improvement of the referral process**

Other respondents made helpful suggestions for improvement of the process:
Medical and Dental Defence Union of Scotland say that they ‘understand that draft regulations exist (following consultation in 2016), setting out when doctors will be obliged to report deaths, but it is uncertain when these may be introduced. We would welcome such guidance as currently Coroners often have their own local guidance, leading currently to uncertainty as to what should be reported, leading to confusion and statistic anomalies.’

Similarly an individual respondent says that ‘...It is not always clear who should go to the coroner. Maybe a guide to which incidents should go to the coroner would help.’

The paperwork already mandated for cremation should be made applicable to all deaths as this would ensure a second doctor review all deaths.

A number of respondents called for training for ‘Junior doctors... in how to write death certificates.’ They say ‘...Part 2 doctors are independent scrutineers of medical practice, which is a system that works well but there should be training in place for doctors doing part 2 cremation forms which currently there is not.’

Any unexpected or unexplained fatality should be referred, particularly if there was a possibility of healthcare error. Trusts where referral rates are low should be investigated for potential underreporting. Though this will require an increase in resources available to the coroner’s office.

An investigating clinician should have an obligation to refer if this has not already taken place by the team in charge of the patient’s care.

The coroner's office should be informed of all deaths in hospital, even expected ones. It would take but a few moments of perusal of the notes to exclude the ones such as advanced malignancy with no last minute change of medication that could have shortened life. It should not be up to the individual clinicians to decide. I know from past experience that cases that should have been notified have not (when I was too junior to object). The coroner would obviously need extra trained staff, but that is probably cheaper than all the current legislation paid for out of taxation.

We need to see the Medical Examiner system introduced to ensure senior medical oversight and responsibility for every Medical Certificate of Cause of Death issued.

A referral to the [police] should only be done if the hospital investigation feels gross negligence (not a mistake) was made.

There should be clearer, plain-language on this; there should be automatic independent referrals; and families should have power to refer.

**Referrals from the coroner to the police**

Arrangements for referrals to the police from the coroner were less clear cut. DAUK wrote that it is generally the coroner who refers to the policy but ‘there is widespread inconsistency as to which cases to report’ and that consistent guidelines need to be developed to assist coroners when deciding which cases to report to the police. DAUK goes on to say that in view of the small number of cases for GNM further support may be
required from the Chief Coroner (beyond Law Sheet No 1) prior to any referral to the police. MDU also noted that it is generally coroners who refer to the police but said it had misgivings about the guidance for coroners in relation to GNM.

The Royal College of Anaesthetists also alluded to inconsistent practice: ‘often made according to local custom and practice, normally driven by instructions from the local coroner. The college goes on to call for ‘greater consistency’ across local coroners over which deaths should be reported. MDDUS echoed this, saying that coroners ‘often have local guidance leading currently to uncertainty as to what should be reported...’

NHS Improvement advise that coroners make two sorts of referral to the police:

- For an investigation under the Coroner’s Act where the Coroner expects a police officer to investigate the death and prepare a file for the inquest by obtaining witness statements and other evidence.
- For a criminal investigation where the Coroner is concerned that the circumstances of the death may involve criminal liability.

Investigating police officers should be clear with the NHS and other organisations when they are acting on behalf of the Coroner to establish the cause of death, rather than investigating a crime. If the matter becomes a criminal investigation, the investigating officer should make it clear to the NHS organisation and others that the status of the investigation and their role in it has changed.

However, we are told that ‘...MDDUS has also encountered situations where there is a lack of clarity as to whether or not the Police are actively investigating a potential GNM charge following a death. This confusion arises because in certain districts, Coroners are assisted in their investigations by a serving Police Officer rather than a permanently-appointed Coroner’s officer; and doctors are naturally alarmed to receive communications from a Police Officer. It is therefore suggested that in any investigations conducted by a Police Officer, there should be absolute clarity about their role and the nature of the investigations that they are undertaking.’

NHS Improvement go on to say that ‘...Where police officers intend to undertake a criminal investigation in healthcare, a memorandum of understanding is available to guide both parties through continuing a safety investigation and effective and timely safety management whilst this is progressed.’

**Referrals to the Crown Office of the Procurator Fiscal in Scotland**

From the responses received from those practising in Scotland, it appears that the process and rules for reporting deaths to the Crown Office of the Procurator Fiscal are clearer to those who interpret them (than their counterparts in England and Wales), or at least there appears to be greater consistency in the awareness of them. The responses were largely descriptive of the process, however there was some indication of perceptions that the process works well/effectively. Comments included the following:

• There are clear mandatory reporting processes for certain deaths to the procurator fiscal\textsuperscript{28}, which include deaths under medical care which are subject to complaints / concerns / negligence etc. In any other situations, this is at the discretion of the doctor certifying death. There has been a move towards consultant / trained GPs completing death certificates themselves, or indeed having to be consulted as the responsible senior clinician by whichever other doctor (in training) is tasked with completing the death certificate.

• Law Society Scotland said that in Scotland the referral was usually made directly by the hospital to the SIFU and the police were instructed by COPFS.

• The Royal College of Psychiatrists (Scotland) wrote that in Scotland the decision to prosecute was first considered by the PF and then authorised by the Lord Advocate.

• ‘In Scotland the referrals are made to the Procurator Fiscal who may have been in discussions with the family. Unlike the English Coroner, the Procurator Fiscal is a prosecuting lawyer and may refer the case to the Sherriff for a Fatal Accident Inquiry form which prosecutions may arise.’

• Deaths may be referred to the Procurator Fiscal in Scotland directly by the police, by the doctor pronouncing life extinct, by the doctor asked to provide a Medical Certificate of Cause of Death (MCCD), following random review of the MCCD by the Death Certification Review Service (only applies to Scotland where MCCDs are subject to a national review system. A sample of MCCDs (approximately 10%) are randomly selected for independent review by Healthcare Improvement Scotland, in order to identify problems and make improvements to the death certification system if necessary.) who may also potentially refer cases of deaths abroad where the body is repatriated to Scotland and there is evidence of potential criminality which may be prosecuted in Scotland.

• ‘The PF have a fairly low threshold for asking the police to gather information (as the PF have no staff directly to do this, so rely on the police). I presume after this it remains the PF’s decision as to whether to take it further.’

• Healthcare Improvement Scotland ‘In Scotland there is a professional obligation to report incidents to the Procurator Fiscal, and advice can also be sought from the Death Certification Review Service.’

• ‘I work in a specialty where there are many fatalities due to severe trauma etc. so am used to doing this. In case of fatality it is usual for the doctor to phone the procurator fiscal. There is a dedicated phone line. An officer takes all the details then they phone you back. I would refer any death that occurs 24 hrs after surgery or on the table. Or any death that was unexpected and unexplained. I would refer any death where there has been signs of trauma or intoxication or anything suspicious. I

think it is the responsibility of the team and anyone who feels it should be done should do it. I do it for my patients or ask one of my junior docs to do it for me. The fiscals office are very helpful.’

• In Primary Care it is usually the GP who is signing the death certificate that discusses matters with the PF office or at times the police. This works reasonably well in respect to suspicious deaths caused by family and third parties but not caused by the GP!

As we saw in responses from doctors practising in England and Wales, a couple medical professionals in Scotland also reported that phone calls/emails to the procurator fiscal are often performed by junior doctors but that they think this should really be done by senior members of the team (registrars/consultants) who are familiar with the case. However one respondent adds that ‘In Scotland a senior doctor, usually but not exclusively a Consultant, will ring the Procurator Fiscal service and discuss the case. Generally, speaking if an issue is felt to be serious enough to warrant referral to the Coroner or Procurator the process of referral should be carried out by a senior doctor, usually a Consultant.’
**Question 28.** What evidence is there that some groups of doctors (by virtue of a protected characteristic) are more or less likely to be subject to investigations leading to charges of GNM/CH than other groups? What are the factors that may be driving a greater likelihood for certain cohorts of doctors to be subject to investigations leading to charges of GNM/CH?

There were 469 responses to this question online.

This question exposed something of a divide between those who were not aware of evidence of any groups being more vulnerable to charges of GNM and those who felt able to identify clear evidence.

Individual medical professionals responding to this question highlight their views about doctors who they ‘feel’ are, or that they think there is ‘no doubt’ about whether they are more likely to be investigated or referred to the police, although many noted that they don’t have or know of evidence to support this.

There were a few responses to this question from family members or patients but there were no common themes amongst their comments. One family member simply told us that they ‘…Not aware of any groups or barriers for doctors in raising concerns.’ Conversely, one other patient or family member tells us that they ‘…have been told there are many by leading groups of doctors. They are afraid they do not want to lose their jobs. Get rid of the NHS ‘Culture.’ BAPIO - They appear to be a very good group so open to debate we are all able to agree to disagree.’

**More likely to be subject to investigations leading to charges of GNM/CH than other groups**

The most commonly reported group of doctors that respondents thought are more likely to be investigated (from all respondent groups) were black minority and ethnic doctors (‘BME’ - 81 times/’black’ – 22 times/’minority’ – 29 times/’minorities’ – 27 times/’ethnic’ – 63 times).

Contrary to the most frequent opinion that BME doctors are more likely to be investigated, a few respondents claim... ‘white males...because they are blamed for everything nowadays.’

The second most commonly reported group were junior doctors junior. The Association of Anaesthetists GBI say for example that ‘there are understandable barriers for trainee doctors who feel that reporting serious incidents or raising concerns may damage their career progress. Overcoming this suspicion is problematic.’

The Royal College of Radiologists suggested that all those doctors who have a transitory relationship with their employer are more at risk – locums, trainees, IMGs and doctors nearing retirement. Similarly, the Medical and Dental Defence Union of Scotland say ‘...those holding shorter-term posts and so less well integrated into local professional networks may be more likely to find themselves in jeopardy.’

Other medical professionals less frequently highlighted the following cohorts of doctors, as more likely to be investigated:
• women
• middle grade doctors
• doctors working less than full time
• new consultants
• doctors not graduating from UK universities (i.e. international medical graduates (IMGs))
• Mental Health doctors- ‘even though suicide is a known risk of mental illness’
• Locum or other peripatetic doctors
• ‘wearing a headscarf obviously makes you more of a potential risk as well as shown in this case. Especially when it comes to trial by media.’
• Middle aged / older males especially of BAME background
• Doctors who are too soft to say no, and carry on working to help out when pressured to do so by managers.
• All doctors - ‘As doctors we are very exposed generally... The buck stops with us, rightly or wrongly.’

• **Particular specialties or areas of practice:**

  • We were repeatedly told ‘Anyone dealing with the acutely physically ill is at great risk, but probably it’s true in acute psychiatry too, it’s just that the index case hasn’t happened yet.’; ‘Doctors in high risk specialities- acute care, obstetrics, emergency medicine, ITU major surgery etc. Working without medical records and unfamiliar patient. In psychiatry this was contributed to by the extraordinary concept of 'never events' as if all risk can be eliminated and if not then it is someone's fault.’

  • General Practice – because of the ‘...Massive and unrelenting workload in general practice, if current trends continue will lead to more investigations. Too many decisions to make, to little time and lack of support such as effective and safe IT systems (lack of communication between hospital and GP).’

**Evidence: criminal investigations and convictions?**

The Faculty of Pharmaceutical Medicine say that on ‘...the basis of the figures presented in the Williams report there is a easily recognised greater number of BAME practitioners in proportion to their numbers in practice.’

Dr Oliver Quick, University of Bristol explains that in fact:

‘In short, there is little reliable hard evidence that some groups are more or less likely to be investigated for GNM. Research that has been conducted has not (as far as I am aware) been able to demonstrate this, although it seems that this research was not able to access reliable data on protected characteristics in order to assess this properly.'
There does appear to be disproportionality in terms of convictions of cases prosecuted with a significantly higher percentage of BAME practitioners being convicted.

Nevertheless, it is likely that disproportionality is a problem beyond the few cases which end up at trial. There has certainly long been anecdotal evidence of this in the form of observations from those involved in the management of such cases (prosecutors) and also those key to aiding decision making (experts) - i.e. remarks that there appear to be a disproportionate number of BAME practitioners being investigated. However, there is no escaping the fact that this issue is poorly understood and requires further more careful research before any conclusions can be drawn.’

Dr Jenny Vaughan responds to this question by quoting Oliver Quick’s work reported in the Medico-Legal Journal in 2017, in which Dr Quick cautions the unreliability of the data, and saying that ‘...unfortunately we can’t speak too confidently about what is going on here.’ But goes on to argue that ‘...the data on conviction rates is quite stark. Between 2012 and 2017, to the best of my knowledge, there have been seven practitioners from the UK and nine practitioners from outside the UK (by place of primary medical qualification) prosecuted, and the conviction rate of cases proceeding to trial is 0% for those from the UK and 78% for those from outside the UK.’

Dr Vaughan adds that ‘...over the last 10 years only BME practitioners have been convicted of GNM in medical cases.’ And makes the suggestion that ‘...there should be a moratorium on all of these cases until the CPS can prove that the process of investigation is not putting some groups at a disadvantage compared to others.’

Dr Quick summarises saying again that ‘clearly further research is needed’ and that ‘...we need a longer time span of cases to measure whether that finding is represented over a longer period of time, but clearly that does raise some suspicion about the possibility (I say no more than that) of prejudice creeping in to the construction of cases.’

A legal professional advises that ‘...There is a slightly circular element to this. In my experience it is so often not the original error but a cover-up which leads to investigators becoming more focused on an incident which in turn leads to considerations of the criminal law. If a BME doctor believes that they are less likely to be treated fairly by the system (whether internal, GMC or police) there is a greater danger they will cover up their errors which is likely to lead to a greater focus upon the original incident. I have no direct evidence that BME professionals are more likely to be prosecuted for the same quality of mistake as a non BME doctor, but there is clearly such a perception which may be accurate. Therefore, based on a summary of the existing research in this area, it would appear that the following factors require closer analysis in this context:

- Medical training and English language proficiency (for non-native speakers) – not just of those charged but others in their clinical teams.
- The ability of groups with certain protected characteristics to to get jobs in better hospitals with better training and supervision.
- It would be naïve to discount the role of prejudice here, beginning with the decision to complain or a refer a case in the first place.
...Ideally, this would be based on comparing the characteristics of the defendant in all cases of deaths associated with medical error, with those that proceed to the investigatory stage, and those which are prosecuted. Obtaining information in terms of the latter two case populations is much more realistic and should be considered a matter of priority.

Association of Surgeons of GB&I was ‘unaware of any robust evidence to suggest that any groups of doctors are proportionately more (or less) likely to be subject to investigations leading to criminal (or civil) charges.’ The Royal College of Physicians and Surgeons Glasgow wrote that there is ‘no evidence in this area’.

Similarly, BMA referred to the very limited data on GNM by protected characteristics.

However, it went on to note work by Professor Robin Ferrer from the 1990s which found that three quarters of those accused of GNM between 1970 and 1999 were of South Asian, SE Asian or African origin. BMA also noted the recent cases of Sellu, Bawa-Garba and Honey Rose have added to a perception that, while prosecutions are rare, BME healthcare workers are more vulnerable. DAUK also used these cases to illustrate the point.

Interestingly, BMA also cites the Lammy review which pointed to racial disparities in the criminal justice system, while noting that CPS charging decisions were generally ‘proportionate’.

**Evidence: no evidence in relation to criminal investigations but other ‘evidence’ of overrepresentation**

Whilst the question was directed specifically at drawing out perceptions about groups that are ‘more or less likely to be subject to investigations leading to charges of GNM/CH’ it appears that many (if not most) individual medical professionals respondents felt that BME doctors were more likely to be complained about or investigated in general, or commented widely about the prevalence of racism, prejudice or bias in the healthcare systems (not necessarily in relation to investigations leading to potential GNM/CH charges). They mostly didn’t relate their comments to any personal experience of certain groups being investigated locally following patient death or being investigated by the police for GNM.

Quite a few respondents point to data held by the colleges. For example a respondent says that the Royal College of General Practice ‘...data base and history reveals that white GPs-in-Training are less likely to fail the assessments than their non whites counter parts. BAPIO Court case is a big example.’ Others point to the ‘...evidence of differential attainment throughout all of medicine.’

NHS England advised that ‘based on audit of statistics (simple audit), practitioners from BAME backgrounds are overrepresented’ in their performance process, ‘as are those who are aged 55 and over or within the first 5 years of their careers.’

**Overrepresentation of BME doctors in ‘GMC’ (135 times) data on fitness to practise processes**

The most frequently cited ‘evidence’ that respondents felt was an indicator that BME doctors would be more likely to be investigated potentially leading to a charge of GNM/CH than other groups, was the data on overrepresentation of BME doctors in GMC fitness to
practise processes. Respondents say for example ‘...whilst we are not aware that there is any evidence that this evidence exists for GNM/CH we note this evidence and are mindful that there may be similar factors operating.’

In particular, the British International Doctors’ Association and the Muslim Doctors Association (amongst others) strongly referred to the over-representation of BME doctors in complaints about to the GMC.

DAUK echoed much of this, saying that BME doctors were more likely to be erased or suspended and more likely to be IMGs and that GMC research showed that BME doctors are more likely to be referred by an employer and undergo a full investigation. DAUK criticises the GMC decision to appeal the MPTS sanction in the case of Dr B-G, comparing the case [inaccurately] with that of Dr Barton.

The Association of Surgeons in Training believe ‘...there is clear evidence that BME doctors are more likely to be subject to investigation leading to charges of GNM than other groups. The GMC has instigated 25 appeals about 23 doctors in relation to Medical Practitioner Tribunal Service (MPTS) decisions since it obtained the power to appeal in December 2015. Of the 16 that proceeded to the High Court, the GMC appeal has been upheld by the High Court in 14 cases. Greater than 60% in the group that constituted the GMC’s appeal against the MPTS decisions came from a BME background even though only 9%-41% of registered medical practitioners in the UK are from a BME background. Furthermore of the seven cases of GNM convictions in the last decade, all were BME though in the case of two (Sellu and Honey Rose) two convictions were overturned on appeal.’

Other individual respondents tell us to look to ‘GMC data on whistleblowers’ (who they see are all or mostly BME doctors). One respondent adds that ‘...The GMC have been referred to as being 'weaponised' with the number of Trust referrals increasing. The threat of referral is now used commonly in many Trusts.’

The Muslim Doctors Association also claims that ‘...the presence of significant missing data precludes any definitive conclusions being drawn. There is a lack of data on factors driving increased referrals... Additionally, the GMC does not regularly gather data on doctors’ religious background, making it impossible to estimate whether doctors of certain religious groups are more likely to be discriminated against. Preliminary research conducted by the Muslims Doctors Association indicates that doctors from minority religious groups and particularly Muslim doctors are likely to experience religious discrimination in the workplace and in training.’

The Hospital Consultants and Specialists Association call for the GMC and MPTS to ‘...further break down their published statistics in order to reveal the gender and racial balance of cases. This would help to maintain focus on this issue and allow for proper public scrutiny.’

**What are the factors that may be driving a greater likelihood for certain cohorts of doctors to be subject to investigations leading to charges of GNM/CH?**

BMA noted that there were other factors at play (as demonstrated by GMC data): being male, working in a high risk specialty, being a locum, being IMG were all considerations. It was difficult to unpick the extent to which ethnicity is the driver. Although one study had
noted found that ethnicity did not drive risk of high impact outcomes, being an IMG (most of whom are BME) did. The source of the complaint was also a factor. In view of this complexity, BMA welcomed the research the GMC had commissioned from Roger Kline to better understand the over-referral of BME doctors. It noted there was plenty of evidence that pointed towards racial inequalities in the NHS. This included: lower success rates in education, training and recruitment; and greater likelihood of experiencing bullying, discrimination and harassment.

**Institutional Racism and societal bias**

In relation to those who believed BME doctors are more likely to be investigated, respondents repeatedly said that this was due to: ‘unconscious’ – 32 times, ‘bias’ – 65 times; ‘racism’ – 62 times; and, ‘prejudice’ – 22 times.

There were a significant proportion of respondents who noted their belief that ‘institutional racism’ (and ‘nationalised racism’) still exists (although some noted that this is ‘less than it used to be’), saying for example ‘...you only have to look at the names on the published list of doctors being investigated by the GMC to know that racism must play a factor.’

Others felt strongly that societal bias or unconscious bias played a role in why they believe BME doctors are more likely to be investigated. They say for example that ‘...patients as a whole complain more about them [non-English doctors] and not for any difference in their management. Some sectors of the public do still have racist views.’ Others cite that it is ‘...possibly due to management prejudice or inability to communicate with some members of this group so informal routes are not used and there may be a premature recourse to the formal route.’ Others highlighted the role of colleagues (other doctors and nursing staff were highlighted) and how their biases may effect whether BME doctors are more likely to be investigated, for example, one respondent says ‘...I suppose unconscious bias towards colleagues may mislead the PF/police when they gather information, which could increase the chances of an investigation.’

A couple of respondents told us that they ‘...suspect it mirrors the overwhelming evidence that being black is an independent predictive risk factor for detention under the Mental Health Act’.

A recurrent theme was that respondents believe that doctors trained outside UK may be assumed to have ‘lesser skills’, be ‘less well trained than those UK trained’, and thus ‘be blamed for errors.’ Including in particular, ‘locums who are less known to departments may also be assumed to has lesser skills.’ One respondent (identifying as an academic) claims that there are ‘...different standards of education prior to serving the NHS.’

One respondent shares their view that ‘...Asian doctors are thought to be crap. This is a historical perspective and is sometimes thought of as true by patients as well. There is a lot of talk about white privilege at the moment and there is some truth to this. As an asian doctor myself, I have always known that I have had to work twice as hard or be twice as nice to be accepted. Much of this sense of expectation is probably so ingrained in me and probably does not reflect reality but its been there for so long, one can't then shake it off.’
We were told that ‘ethnic bias, [is an] ‘easy way out for all parties’ and whilst all junior doctors are at greater risk of being investigated, it is ‘more so for BME doctors as they can be more isolated than those speciality trainees who have the backing of their deaneries if needed.’ Another respondent claims ‘It is always easy to lay the blame at the door of locums. They are often drafted in at short notice to cover weekends/bank holidays etc and often belong to the group which is the subject of this question. They get virtually no induction and little support when on the shop floor. They have invariably left by the time an incident is investigated and do not receive the same support as permanent members of staff.’

Many respondents reported their belief that they do not think it is ‘simple racism’ and say that the reasons why BME doctors in particular are more likely to be investigated is multifactorial. Indeed one patient or family member advises that it is ‘...Multivariate factors, which largely can be avoided with proper actions and appropriate workload correct ratio. Proper working conditions.’ Another patient or family member believes that it is down to ‘...incompetence, lack of supervision, poor leadership/mentoring and failure of the regulating body i.e. GMC to act on concerns raised.’

Communication (61 times) and language (53 times) barriers and relationship/rapport building

Many individual respondents felt that doctors with English as a second language ('English' – 50 times) were more vulnerable. Saying for example:

‘Bereaved relatives will be more likely to wish to prosecute a doctor if their meetings with the doctor conform to adverse stereotypes and prejudices that the bereaved may hold - so:

- doctors that communicate badly for whatever reason, e.g. come across in ways that antagonise the relatives [lack empathy, shut down, unapologetic?, poor English or heavily accented English, speech impediments that make it difficult for relatives to understand them],
- doctors not of the same race as the relatives, or if the relatives are racially prejudiced
- perhaps religious prejudices and differences may play a part and perceived sexuality.’

One patient or family member held the strong view that ‘...Doctors and nurses should not be allowed to practise in the UK with foreign qualifications only. They should be made to take a one year training course at an approved UK academic university to prove their skill and adapt to UK patients needs, before being allowed to work in NHS or with UK patients. This is essential.’

Medical and Dental Defence Union of Scotland believes ‘...there must at least be a theoretical risk that those doctors with lower, albeit still acceptable, standards of English language proficiency.’ The Royal College of Surgeons Edinburgh go further and point to
previous academic publications which have referred to factors including cultural differences particularly related to verbal and non-verbal communication, and learning environment. An individual tells us that ‘...Doctors whose first language isn’t English are less likely to present themselves well in a coroners court.’

We were repeatedly told that ‘poor communication skills, either in verbal terms, or emotional terms, is the greatest predictor.’ ‘...a white British doctor with recent training in communication skills (this is a bigger feature of medical school training these days) is at lower risk of receiving a complaint or being investigated in this way.’

‘Some overseas doctors are less good at communication skills and relating to patients due to the culture they were trained in, but by working in the UK and in the NHS, [they] should be trained to improve in this. Unfortunately service needs, and these doctors being in posts where they are less of a training priority can mean that this is difficult to achieve. The new RCOG curriculum is being designed to try and redress this.’

A respondent who tells us they are a female consultant surgeon argues that ‘...there are real day to day problems for people in whom English is not their first language. Their communication skills are not as good. They are less likely to pick up on nuances and body language of patients and relatives and find it more difficult to talk to relatives especially when strong regional accents (on both sides) are involved. I see this daily in my own practice. Good communication is vital in day to day life in the NHS and many problems are caused by poor communication. Many problems can be solved at an early stage by talking to patients and relative openly and in language they can understand. Some Asian/African men have problems talking to women or taking orders from women, especially if the woman is of a higher grade than them. I have experienced this first hand. This can lead to problems. Some Asian doctors become very subservient and find it difficult to make eye contact if they feel they are being criticised. They tell me that this is a cultural thing. I have explained to them that this makes them seem to be ‘more guilty’ than they really are. I suspect this body language makes it more likely that they will be used as scapegoats.’

**Cultural (50 times) differences**

Another recurrent theme linked to communication and language barriers above, was that doctors ‘from countries that are culturally significantly different (e.g. Indian subcontinent) are far more likely to be subject to charges’ (noting that some of this may be direct racism). We were told that BME doctors in particular will ‘may struggle to accommodate an unfamiliar culture.’

‘Some overseas doctors come from a culture where medicine is still practised paternalistically. This may also be why they have lower pass rates for MRCPCH where is lot of emphasis on listening skills.’ Another respondent adds that ‘...British culture is very difficult to cope with coming from for example Pakistan or India. High amount of drug and

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29 University of Bradford: The Involvement of Black and Minority Ethnic Staff in NHS Disciplinary Proceedings (2010) [https://www.brad.ac.uk/research/media/CIFD-Briefing-9-BME-disciplinaries.pdf](https://www.brad.ac.uk/research/media/CIFD-Briefing-9-BME-disciplinaries.pdf)
alcohol use. Abusive threatening patients. Self harm etc can be very difficult to come to terms with.’

Respondents argue that ‘Foreign doctors (‘foreign’ - 25 times) are more vulnerable... because they may have more difficulty in establishing an empathetic relationship with patients and their families. Some may come across as disdainful or arrogant.’

Others explain that other factors which influence doctors being more likely to be investigated include: working in unfamiliar [healthcare/NHS?] systems; unfamiliarity with the legal system; poor access to funds to support a legal fight; poor access to support generally (including peer, and pastoral support); poor membership of unions or defence organisations; and a different approach to accusations that may seem more defensive. One respondent writes ‘...Perhaps doctors who have moved into this country are too trusting of the system and don't know where to turn for defence compared to British born doctors.’

One respondent shared their opinion that doctors ‘...who have a medical degree from outside the UK potentially have a future career abroad, and there is a trend to skip off when the GMC threatens. There will always be an outcome bias against this group for statistical reasons.’ Although, they did not provide any evidence of this.

**Less likely to be investigated or lower risk of investigation or protection from investigation for white British males**

A number of respondents argued that there is protection from investigation for some, eg british, (26 times) senior, white (84 times) male. There are those considered ‘the Great and the Good’ who are protected through college affiliation (‘protected’ 26 times, although noting that this word may also have been used in relation to describing ‘protected characteristics’).

Some respondents highlighted that the people who make the ‘decisions to refer’ [presumably to the GMC or police] ‘tend to be older white and English.’ One respondent says ‘...The investigation of the case involving Dr Bawa Garba was by a purely white panel [perhaps they are referring to MPTS?]...If Dr Bawa-Garba was a white English doctor, it is unlikely that her case would have progressed.’

Another respondent says they have ‘...no doubts that very 'senior' clinicians often escape criticism because of their status. I also have no doubts that the racism that was absolutely rife when I was appointed as a consultant in 1984 still exists though it is now more hidden.’ Similarly, other respondent added:

- There is a seemingly overt culture of protecting the British male upper classes (usually privately educated) in medicine.
- There is still a bit of an "old boys" network in place. This protects older white men in positions of power in Government, medicine and management but as the years go on this is definitely being eroded as these types retire. I don't see it so much in younger consultants who in general are much more open.
- ‘defence organisations does recognise that so being white is protective characteristic.’
• ‘The GMC have also reported that there may be under-representation of doctors from a white background and have suggested doctors from this group may find it easier to get away with mistakes.’
Question 29. Do you think there are barriers or impediments for some groups of doctors to report serious incidents and raise concerns? More specifically are there additional barriers for BME (black, minority and ethnic) doctors? If so, which groups are affected by this and how can those barriers be removed?

There were 459 responses to this question online. ‘BME’ was used in answer to this question 110 times. The most commonly used word to describe a barrier amongst all respondent groups was ‘fear’ (53 times), closely followed by ‘culture’ (51 times (plus ‘cultural’ – 17 times)). ‘Blame’ was also highly mentioned - 30 times.

There were a number of recurrent themes identified in responses to the previous question (asking for evidence of groups more likely to be investigated) raised again here.

Patients and families

Many of the responses from patients and families agreed with the views expressed by many medical professionals. Here are some examples of their comments:

- ‘Yes, the GMC is essentially a racist organisation. It needs to be held accountable for systematic racism and the death of 85 doctors in the last 10 years. I am someone who has lost a child in the care of the NHS. However, blaming doctors isn’t the way forward. Being racist and uncaring about scores of deaths will only undermine trust.’
- ‘Race of doctors. Doctors with poor communication skills. Certain specialities are higher risk.’
- ‘Any doctor in training liable not to be able to progress with career if they are whistle-blower.’
- ‘Junior doctors left unsupported, high demand, low staffing levels, blame culture, management pressure, bullying.’

The Association of Surgeons of GB & NI was unaware of any evidence to support the suggestion that there are particular barriers for BME doctors.

The BMA response, on the other hand, pointed to recent BMA survey showing that BME doctors are less likely to say they were confident about raising concerns than their white counterparts. Barriers for raising concerns included: workload pressures, lack of feedback, fear and distrust of the system (more BME than white doctors felt this), fear of being blamed (more so for BME doctors), lack of commitment in the system to learning lessons from errors.

The BMA response also highlighted the following as likely to contribute to distrust and fearfulness: high profile GNM prosecutions against BME doctors, over-representation of BME in GMC complaints, over-representation of BME in employer disciplinary processes, bullying and harassment at work.
The factors identified by BMA were echoed in many of the other responses. Doctors Association UK, for instance, also suggests that high profile cases may ‘influence behaviours of BAME doctors who are fearful of raising concerns’.

The National Guardian's Office and the GMC point the Francis Freedom to Speak up review which found that, for example BME staff can feel 'particularly vulnerable if they raise a concern'. BME staff reported that, after speaking up, they were more likely to report being victimised or ignored by management than staff from a white background. The review also found that locums, agency and bank staff are also particularly vulnerable when they speak up due to ‘the temporary or short-term nature of their ‘contracts.’

**Other groups of doctors with barriers to raising concerns**

The National Guardians Office go on to say ‘...there may be others who also face barriers and impediments to speaking up. For instance, the perceived hierarchies among doctors may be a potential impediment to the ability of some doctors to speak up. An anaesthetist may be more reluctant to speak up about a surgeon. Similarly, SAS doctors, less than full time and trainee and junior doctors may feel less free to speak up about more senior colleagues. An individual may also be impeded from speaking up by virtue of their particular circumstances e.g. a doctor may want to speak up about a matter in which their line managers or educational supervisors are implicated or who have ignored speaking up in the past. ’

The otherwise upbeat response from NHS Providers noted that the NHS National Guardian for Freedom to Speak Up published case reviews of cultural barriers to speaking up and found that in these cases perception of cultural bias against BME doctors contributed to problems with speaking up. This was confirmed by the results of the NHS Survey.

Many respondents say that doctors in training/trainees/junior doctors (‘training’ – 48 times; ‘trainees’ – 21 times; and, ‘junior’ 47 times) are more reluctant to raise concerns for ‘fear of their career progression being affected,’ claiming that... ‘Junior staff whose careers and employment are dependent upon satisfactory references from those who might be responsible for the incidents or concerns.’ They also say that... ‘BME doctors are often in junior positions and more peripatetic and so venerable and bullied.’

The Association of Surgeons in Training (ASiT) argue that ‘...as front-line healthcare staff, doctors in surgical training occupy a unique organizational space rotating through hospitals and services in which they witness first hand both good and bad practice. This puts trainees in a clear position to identify and raise patient safety issues, and to contribute to discussions regarding quality and safety improvement. However, there are a number of real and perceived barriers to trainees doing so. These include concerns about the impact on training assessments and career progression, and uncertainty about the appropriate route through which concerns should be voiced. In 2013, ASiT surveyed delegates attending their
International Conference on such barriers... The results highlight worrying issues around reporting concerns, with trainees often “silent witnesses” to poor performance in healthcare. Adverse events must provide opportunities for learning to improve future outcomes. In response to these findings ASiT made recommendations, including (but not limited to): creation of a positive workplace culture, promoting the active involvement of trainees in quality improvement discussions, with clear mechanisms for trainees to raise concerns.’

The Royal College of Pathologists saw the issue as common to all doctors who ‘...feel they will become scapegoats...if they are involved in any serious incident...and this may hamper reporting of such incidents’.

One respondent shares their personal experience of being investigated and says ‘...where a doctor of any background is at the hands of a vindictive small group of powerful doctors prejudice comes into play. Barristers will tell you that the trigger for many investigations is professional envy. This is hard to believe but is true.’

The Royal College of Radiologists (RCR) suggest that being new to a department could act as a barrier as well as fear of the impact on a doctor’s future career. But more specifically, RCR identified that BME doctors may feel marginalised and so be reluctant to raise concerns.

Tom Holland’s response linked to the value of learning: removing barriers can only be done by making admission of mistakes ‘a positive...exercise’.

MDDUS referred to doctors’ perceptions that they may, themselves, become the subject of disciplinary or regulatory proceedings.

**Fear generated from treatment of high profile whistleblowers**

Dr Jenny Vaughan says that ‘...there are multiple barriers and unfortunately there are specific groups of doctors who are disenfranchised by this. Examples include Raj Mattu nearly 20 years ago and more recently Edwin Jesuadson. Whistleblowers are not treated well by the system. Dr Chris Day has spent years fighting his case because he raised concerns about patient safety at Woolwich hospital and it has had a massive impact on his livelihood and career.’

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31 60% of trainees reported previous concerns over practices and behavior of colleagues that might pose risks to patient care. However, 53% did not escalate these concerns. 37% percent of trainees also reported concerns over hospital policies, protocols or systems that might pose a risk to patient care, with 46% (n=82) not escalating such concerns. Respondents highlighted fear of personal vilification or reprisal (47%), fear of impact on career (43%) and a lack of confidence in the process (36%) as barriers to reporting concerns. More senior trainees were significantly more likely to raise concerns than more junior grades (p < 0.0001).
A number of other medical professionals also highlighted the same whistleblower cases as evidence of the mistreatment of doctors who raise patient safety concerns and why they fear being 'singled out'/scapegoated, saying that… ‘doctors in training may also be fearful to raise concerns as a consequence of the effects of this on high profile whistle blowers…’

The following comment demonstrates the strength of feeling from respondents in this regard:

'I've tried to make suggestions / raise concerns and they have always been brushed under the carpet so I give up. Makes me terrified, feel powerless to improve systems and beaten down so I don't do it any more. Put up and shut up or leave and perhaps be blacklisted.’

Another respondent argues that ‘...barriers exist for doctors of all ethnic backgrounds and is a result of "learnt helplessness" and loss of hope about not being listened to or not being taken seriously caused by past experience of such attempts and being accused of having "lack of resilience".’

There were many calls from respondents to create effective mechanisms for protecting whistleblowers and to ensure that ‘staff feel valued and empowered to pass on concerns. When staff do raise concerns these should be celebrated, not punished.’

**Additional barriers for overseas trained doctors - visas**

A few respondents in this category told us that there is further vulnerability for ‘overseas trained’/‘foreign’ doctors from visa restrictions. One elaborates saying …’if you rely on a sponsor for a Visa and money coming into your account from an employer, of course you won't raise concerns if you are going to be suspended without pay.’

Many others highlight the cultural differences that may be a factor/barrier in raising concerns:

• ‘There are some non-UK doctors who seem to think suppressing truth and protecting the reputation of the organisation is the most important thing, with attitudes of 40 years ago, probably from being taught medicine in this sort of environment, to a greater extent than UK doctors.’

• ‘There are some cultures in which admitting error is considered a sign of weakness.’

Others reflect more on the culture in the NHS than the individual doctor’s cultural background, for example:

There were some respondents who argued that there is a lack of holding to account of healthcare organisations to improve when patient safety concerns are raised and highlighted issues with the effectiveness of the current reporting systems, which the following comments demonstrate:

• ‘[There is a] disconnection between nursing lead patient safety / datix systems and medical reporting. [There is also a] lack of genuine positive action after reporting and instead meaningless action plans.’

• ‘In primary care some providers have a very poor record with insufficient staffing, training and poor safety in my opinion. The CCG say that the GMS contract is so loose it is hard to hold them to account and even if they did who would take over the contract? Companies aren't lining up - quite the Reverse.’

**Culture of bullying and undermining**
As we saw in responses to previous questions there is a recurrent theme that respondents claim ‘The NHS has a culture of bullying, undermining and harassment across the board.’ The National Guardians Office tells us that Guardians ‘have received over six thousand concerns in the year 2017-18 ...45% relate to bullying and harassment.’

In addition, we are told that ‘...there is a real issue around being able to speak up, due to power differentials, hierarchy, perceived negative career impacts and the belief that it won’t make a difference anyway. Those from BME communities are impacted even more by these, as well as language barriers and different cultural beliefs about the above. These barriers can only be removed by wide sweeping culture change across the NHS. This can also be facilitated by novel reporting methods, robust support networks and legislation change about protecting those who do speak up against negative culture.’

Respondents add that ‘...trusts are resistant to the raising of concerns by any professional. The process of raising concerns is intimidating and Deanery representatives or managers to whom concerns are raised initially fail to be supportive and in fact can be threatening.’

**How can those barriers be removed?**

NHS Improvement advises that there is a ‘need to promote a commitment to equality, diversity and inclusion (ED&I) to help staff to be treated fairly and consistently. The Norman Williams review recommended that guidance on this is considered for inclusion in future iterations of the Serious Incident Framework.’

A number of respondents call for ‘increased and mandatory training videos and education on prejudice’. The Royal College of Surgeons Edinburgh ‘...suggests that all healthcare staff should undergo unconscious bias training- not just for staff-staff interactions, but for staff-patient interactions. More research needs to be done, specifically looking at evidencing potential reasons for cultural differences.’ Faculty of Pharmaceutical Medicine also call for all employees in the NHS to be ‘trained and tested the recognition and responsibilities on diversity and disability. To refuse to be open and accepting of diversity should be considered as a barrier to employment. Expressions of bias again should be considered as a barrier to employment. This is an important aspect of the annual appraisal of every doctor.’

NHS Providers noted that the National Guardian’s self-review guidance for NHS providers and NHS Workforce Race Equality Standard are mechanisms for greater inclusion and equality but they need to be prioritised at local level.

The National Guardians Office advise that ‘...Ultimately, the groups that face barriers and impediments to speaking up may vary and depends on the workplace in question.... To eliminate the barriers and impediments that various groups of staff face when speaking up, it is important ensure that the speaking up arrangements in organisations meet the needs of all workers...To be able to combat these barriers and impediments, we would suggest that organisations need to carry out an assessment of what barriers their doctors (and other workers) face when speaking up, and whether certain groups are particularly vulnerable. Based on the intelligence provided by such an assessment, an organisation can attempt to combat these barriers and impediments to speaking up.'
The speaking up arrangements of organisation should provide workers with options as to whom they could approach to speak up, and these options should cater to all workers. There has been good practice demonstrated in trusts who have taken steps to encourage speaking up from vulnerable groups including junior doctors, for example attending junior doctor induction meetings, joint working with the Guardian of Safe Working and appointing doctors at different levels of seniority to the Freedom to Speak Up Guardian role. The speaking up arrangements of organisation should provide workers with options as to whom they could approach to speak up, and these options should cater to all workers. There has been good practice demonstrated in trusts who have taken steps to encourage speaking up from vulnerable groups including junior doctors, for example attending junior doctor induction meetings, joint working with the Guardian of Safe Working and appointing doctors at different levels of seniority to the Freedom to Speak Up Guardian role. The Freedom to Speak Up Guardian role was one of the key recommendations made by Sir Robert Francis in “Freedom to Speak Up” in 2015. The Guardian role exists to, among other things, support and empower individuals and teams to speak up. It exists to provide an independent and additional channel through which workers can speak up, and to work proactively to advocate for the elimination of barriers to speaking up. The standard NHS contract now requires all trusts and foundation trusts to have in place a Freedom to Speak Up Guardian. There are now over 700 guardians and supporting roles across NHS trusts and foundation trusts, Arms-length bodies and private providers.

Other suggestions for improvement included:

- There needs to be greater diversity at the higher levels (snowy white peaks).
- The role of educational supervisors has formative and summative parts - these should be separated.
- There are groups that say they cater to BME Doctors and they would handle all types of cases, but this makes it an 'us versus them' scenario and think it could be best avoided. The MDU and MPS must do more for doctors.
- In the aviation industry, it is recognised that the hierarchical approach can impede effective team working and leads to a higher accident rate. Perhaps this should be recognised in medicine. Some respondents call for "...Non-hierarchical teams/less hierarchical teams in all areas of medicine i.e. the airline model so that all serious incidents and concerns can be aired openly. Regular time-slots and structures [e.g. SEA] to raise concerns should be created but that implies that doctors are not living in very over-pressurised systems. The last thing they need is more meetings! But unless they are monthly and valuable they will not happen. If no one puts any items on the agenda they can be cancelled, or very brief depending on item."
- Providing ways of raising concerns anonymously, or by reducing the blame culture. An anonymous reporting process could be instituted to track trends and identify potential areas of concern. Although this could be open to abuse technology should be able to identify areas of genuine concern. They add that ‘...independent well publicised reporting processes would help.’
- Far greater highlighting to all doctors (especially junior) of the adversarial nature of complaints process investigation and the need to have adequate support (informal and medicolegal).
- The makeup of the GMC and procedures it uses should be reviewed.

32 the Freedom to Speak Up Guardian role was one of the key recommendations made by Sir Robert Francis in “Freedom to Speak Up” in 2015. The Guardian role exists to, among other things, support and empower individuals and teams to speak up. It exists to provide an independent and additional channel through which workers can speak up, and to work proactively to advocate for the elimination of barriers to speaking up. The standard NHS contract now requires all trusts and foundation trusts to have in place a Freedom to Speak Up Guardian. There are now over 700 guardians and supporting roles across NHS trusts and foundation trusts, Arms-length bodies and private providers.


- ‘We need to make this overt to elicit change—eg Schwartz rounds to untangle unconscious bias—we ran one in GSTT—it was really powerful!’

- The barriers can only be removed if we are more inclusive and if decision making and sentencing is seen to be more fair then it is currently perceived to be.

- The encouragement of an open and honest culture allowing for the admittance to errors without consequent sanction is crucial. This includes the creation of a mechanism for effective protection of whistleblowers.

- For doctors entering the UK system from overseas for the first time, it’s important they have appropriate induction, particularly for those from outside of the UK and Ireland who train in non-JCST accredited programmes. Appropriate induction and phased start of work with a period of shadowing may be needed. If someone is identified to be struggling, they should be mentored and given appropriate opportunity to develop skills in a safe way. That may mean a period of not doing overnight call until trained or being supernumerary for a while. This approach would be safer for patients and doctors.

- One legal professional suggests a ‘buddying up/mentoring system…In our chambers we have created for the pupils and very junior members, an aunt and uncle scheme, the persons appointed as uncles and aunts are deliberately relatively junior themselves to allow for a bridge to be created. Pupils have now used this process a number of times to bring concerns to the attention of the aunt and uncle who can then filter those concerns upwards. For those tenants under three years call each has to appoint a senior member as mentor.’

- The Medical and Dental Defence Union of Scotland say that ‘…genuine safe spaces (independent of Trusts, see above) would encourage a more open, reflective culture and would enable all clinicians to voice any concerns that they may have without fear of recrimination.’

- The Muslim Doctors Association say they ‘are conducting research to explore this in more depth and to devise recommendations on how best to overcome these barriers’. In the interim they recommend:
  - The need for more data on experiences of front line doctors with protected characteristics who have been involved in serious clinical incidents
  - Further studies to explore the prevalence and impact of religious discrimination on NHS staff.
  - Training and staff awareness on cultural and faith-sensitive issues.
  - Safeguards for staff who want to raise concerns.


**Question 30. What is your knowledge or experience of cases involving clinical fatalities that have been referred to the police or procurator fiscal? What can we learn from the way those cases have been dealt with?**

There were 426 responses to this question online.

In relation to coronial proceedings (in England and Wales) we were repeatedly told that:

- coronial processes/approaches are very variable
- Healthcare staff worry hugely about their attendance at coroners court
- There appears to be wide variation over which suspected GNM cases are referred to the police for investigation.
- cases are referred for police investigation prematurely or inappropriately
- There are no robust or consistent mechanisms for clinical teams to receive learning from coronal proceedings
- Coroners are pressurised by family members

In relation to police investigations (in England and Wales) we were repeatedly told that:

- police forces locally have insufficient specialist expertise to properly investigate fatalities in complex clinical settings.
- Often cases about GNM are referred to the Crown Prosecution Service (CPS) after a lengthy period of time only to be advised that the case should not proceed
- If police have received advice from experts this tends to have painted a more idealised picture of healthcare than exists in normal / routine practice
- Investigations can be lengthy – sometimes as much as three years
- The delays detrimentally impact on the family as well as the doctor
- Doctors are put under stress
- there is no pastoral or procedural support for doctors only formal legal advice
- there are far more investigations and prosecutions of healthcare professionals for GNM than there are successful convictions
- police are pressurised by family members
- effective communication between the police/trust/individuals concerned is not happening

The BMA noted a number of issues with referrals to the police or Procurator Fiscal (PF).

- Investigations can be lengthy – sometimes as much as three years
- Doctors are put under stress and the NHS is denied the services of a doctor
- The lack of a dedicated police GNM unit exacerbates the delays.

In terms of solutions, the BMA wanted to see:

- A national police unit for GNM in healthcare cases to give more consistency, reliability and quicker decisions
- Encourage early liaison between the police and CPS to decide which cases to prosecute.

Building on the point about the need for timeous decisions the MDDUS wrote that most cases referred to the police or PF do not proceed. It was therefore important that there are ‘prompt’ investigations in order to avoid the possibility or need for lengthy suspensions and the consequent impact on both individuals and services.

DAUK also referred to lengthy delays is before decisions are reached and the damaging effects of this on both doctors and families, regardless of whether the case proceeds.
Prompt referral of cases to the CPS would help clinicians who are not to be charged. DAUK also noted that in Scotland prosecutions must be in the public interest and have the approval of the PF and the Lord Advocate.

The Medical Schools Council noted that there is no pastoral or procedural support for doctors only formal legal advice. ‘It is a very alien environment for clinicians’.

The Royal College of Physicians and Surgeons Glasgow echoed this, saying that the ‘systems in the UK are adversarial and as such will always consider blame. There is no pastoral or procedural support…’

The Royal College of Anaesthetists wrote that ‘coronial processes …are very variable and may often change quite suddenly in a particular jurisdiction when one coroner retires and another takes up the post’. They also note that there ‘must be better consistency of coronial inquiries and processes [so that families] have access to equality of justice’.

The Royal College of Radiologists noted that there was a lack of formal feedback mechanism from coroners’ procedures.

The Royal College Surgeons told us that they have ‘…experience of supporting healthcare organisations with investigations into adverse events through our Invited Review Mechanism (IRM) service that provides expert independent and objective advice when an external expert opinion is requested. Through this work we have experience of a small number of cases that have been subject to an invited review being considered for referral to the police for gross negligence manslaughter (GNM). Our experience of this work has demonstrated the need for greater consistency around how GNM cases are initiated and investigated. We understand there are far more investigations and prosecutions of healthcare professionals for GNM than there are successful convictions. It would be useful to explore this discrepancy to ensure that GNM charges are only applied in extreme cases...We feel that hospitals, coroners, the police and the Crown Prosecution Service (CPS) would benefit from better support and guidance to enhance understanding on when to pursue charges of GNM. This guidance should define the high threshold that has to be met before an unexpected death can be considered criminal and highlight the significant role that systematic failures can play when deaths occur in a medical setting.’

**Medical Profession**

Over 20 years as a consultant I have seen coroners inquests become more thorough, although often still relying on a "local expert" to provide clinical advice to the coroner. The narrative verdict helps address some of the concerns of relatives, but the process is not an exhaustive investigation into the event, and unless the role of the coroners inquest is to change it will remain so.

Sometimes, the police proceed with extensive investigations of health professionals or parents without a particularly good reason. I think this is when families / politicians / media drive investigations. In other words, decision making seems to have a strong influence from media and politicians, which is not a good or balanced drive, eg look at the outrageous investigations of Professor Meadow, Professor Southall, Dr Al-Zayyat
Patients and Families responses

The only discernible common theme from these responses were perceptions of lack of transparency (or cover up) and presence of bias:

- 'We can learn that the GMC is seriously biased against doctors.'
- 'Due to the fact the Trusts are conducting their own investigation into a death for the coroner no meaningful investigation truly takes place.'
- 'I reported to the police they said no neglect as safeguard lead withheld safe referral from trust ward sister she made said neglect of care of mam withheld from coroner'
- 'I attended a coroners court in London in March 2005. Following the unexplained death of my cousin in Charing Cross Hospital. Although I was permitted to see the medical records of the deceased, none of the family present were permitted to address the coroner or the party who read out evidence. The hearing took about five minutes and the coroner read out a simple statement of death and then we were dismissed. In my view this was not an acceptable procedure.'
- 'My daughters death was not reported to the Coroner until eight years after her death. Doctors had covered up her death in 1996 and it was only through the broadcasting of a TV documentary in 2004 following the deaths of other children that we as parents returned to the hospital. A Coroner's inquest was held in 2006. The cover up continued, the Coroner was misled and attempts were made by the Health Trust to exclude my daughters death from an ongoing public inquiry. The public inquiry (IHRDNI) was set up in 2004 and published its report in January 2018. Its findings are damming and shocking. The Coroner opened a second and fresh inquest into my daughters death in May 2018 but has now adjourned as The Police Service of Northern Ireland are currently investigating criminal proceedings with regard to gross negligence manslaughter, misconduct in public office, perjury and perverting the course of justice.'
- 'The coroner has referred the case to the police on suspicion of gross negligence manslaughter.'
- 'The pathologist, and microbiologist do a proper job if they are given the right samples, especially the microbiologist, but they are not given the correct samples. Example: Blood taken immediately from the deceased, eye fluids, and bodily (skin) fluids. In my case none of this have been done, despite requesting immediately Post Mortem to be done. Why? Is simple, to cover up as after 24 hours the blood is compromised!'
- 'The crown prosecution services are discriminative and do not recognise crimes against patients suffering with dementia. They state that they are 'unreliable witnesses.' This is showing alack of knowledge of empathy of the condition and is discriminative, and is unacceptable in 2018. The police choose the easy not complicated cases to prosecute, and are heavily influenced towards the side of the trust and medics. They are not acting impartially.'

Legal profession

BLM

We have dealt with a large number of cases in which a Coroner has referred a suspicious death for investigation by the Police either in advance of or as a result of evidence received during the inquest proceedings. Such cases include clinical fatalities in hospital, the community, in residential/care homes and in prisons.

In our experience of Coroners in England and Wales, we find that a case is referred for police investigation prematurely or inappropriately due to a lack of knowledge or understanding of medicine on the part of the (usually non-medically qualified) Coroner; as a result of pressure exerted by or on behalf of a (lay) family; in consequence of evidence
received during the course of an inquest or from a Coroner’s findings and conclusion in respect of a death.

Cases involving inappropriate referral result in unnecessary stress and anxiety for the doctor. This is often compounded by lengthy police investigations which, in our experience, is more often than due to a lack of medical knowledge and/or understanding of the relevant medical issues within the Police.

We have particular experience of inexperienced police officers seeking to explain - in witness statements prepared on behalf of doctors - complex medical language and procedures in layman’s terms and in language that would not necessarily be used by a doctor. This has resulted in expert witnesses unfairly opining that a doctor lacks the requisite knowledge or skills whereas the statement, in fact, reflect the investigating police officer’s understanding of those particular issues.

That said, we also have experience of dealing with cases which, to the experienced medico-legal/inquest lawyer, fall squarely within the remit of gross negligence manslaughter but do not result in a police referral. Again, most often in consequence of a lack of knowledge and/or understanding on the part of the Coroner.

On the basis of our experience, we suggest that investigation of serious suspicious clinical fatalities should be undertaken by a specially trained and dedicated unit, as is the case with serious fraud or terrorism cases. Our learning suggests that, sadly, although somewhat understandably, there is a lack of knowledge and/or understanding of complex and even basic features of medicine by those trusted with investigating alleged criminal culpability arising from such cases.’

**Professional Representative/ organisation or Trade body**

Royal college of surgeons

There appears to be wide variation over which suspected GNM cases are referred to the police for investigation. With many referrals coming from coroners, clearer guidance for this group in particular would help to ensure only appropriate cases of GNM are investigated. Moreover to improve consistency, we suggest cases should only be referred after consultation with a senior figure such as the Chief Coroner.

AAGBI

As an organisation we do not have ‘corporate’ experience. However, as individuals we are aware of many inconsistencies. A more systematic approach, using a defined process would help both the quality of each investigation, and assist the individuals involved – both the family and the staff involved.

One element that is particularly stressful for the doctor is the immediate exclusion from work and from contacts with colleagues, who are often also personal friends. It would be helpful if a way could be found to keep them at work.

From several cases that have been prominent in recent times, there appears to be a “them vs us” attitude and that the police/CPS will look to prepare as damning a case as possible.
We believe cases should be presented impartially, rather than selectively choosing evidence to suited conviction and ignoring other evidence. In the HBG case, the authorities overlooked the involvement/culpability of senior clinicians and indeed the culpability of the trust for putting a junior doctor into an impossible situation.

Muslim Doctors Association referenced the R vs Dr Cornish & Maidstone – Tunbridge Wells (2016) case, which they say highlights the problem. ‘In this case, Dr Cornish (a foreign trained consultant anaesthetist) was charged with GNM. The CPS had determined with presumed 'expert' advice that Dr Cornish was negligent for not intubating a patient. Following 7 days of trial, the case collapsed, because it transpired, that not only were Dr Cornish’s actions in line with the trusts own guidelines for difficult intubations, but that his actions were also in keeping with national guidance. This resulted in a shocking waste of time, public money, and resources but also equally importantly, irreversible damage to a doctor’s life and career not least due to a vicious media campaign against him.’

The Hospital Consultants and Specialists Association (HCSA) believes that police forces locally have insufficient specialist expertise to properly investigate fatalities in complex clinical settings. We therefore advocate the establishment of a specialist police team, working with the Attorney General who would fully assess the merits of a case before any decision to charge individuals was made.

The Doctors’ Association (UK)

These cases are often very complex and time consuming. Not only does their complexity lead to distress for families, but also for all the clinical staff involved. We have seen in recent years how the length it takes to arrive at a conclusion has had immeasurable negative impact on the mental health of doctors. Doctor suicides whilst investigations are ongoing are on the increase. There is little support for doctors in these circumstances and unless doctors have a support network many feel isolated, impacting on their mental health further. Families are left without the vital answers of what ultimately happened to their loved ones. The length of an investigation therefore has a negative impact on them too. Often cases about GNM are referred to the Crown Prosecution Service (CPS) after a lengthy period of time only to be advised that the case should not proceed. An early and prompt assessment of evidence should be made by the CPS, this would seek to clear clinicians who should not be charged. This would also return vital clinical staff to the NHS where they can continue to care for patients. The Scottish procurator fiscal service is also under resourced. There is therefore a risk that cases of culpable homicide in Scotland may not reach a timely conclusion. However, there is a need for a healthcare professional’s conviction to be in the public interest. This, in combination with the need for approval by the procurator fiscal and Lord Advocate balances the need for justice with supporting a culture of patient safety.

Medical and Dental Defence Union of Scotland

the vast majority do not proceed. Consequently, we recognise the importance of prompt investigations in order to avoid the possibility or need for lengthy suspensions and the consequent adverse impact both on individuals and for services, as well as the need for clear communication on the progress of investigations in order to diminish anxiety.
Systems regulator

NHS Improvement

The experience of the patient safety team in NHSI has related to a small number of cases where the police have been asked to investigate an incident with a view to considering prosecution. They have usually come across guidance we have issued that relates to the type of care or the incident in question and have contacted us to understand more about our guidance and how it relates to their investigation. We have found they are generally very receptive to our expert input. They appear usually to have very limited, or no, understanding of the normal delivery of healthcare. If they have received advice from experts already this tends to have painted a more idealised picture of healthcare than exists in normal / routine practice, possibly as a result of seeking ‘experts’ in an academic sense rather than people who are currently, actively delivering healthcare of the type relevant to the incident.

We have been able to describe the factors that can impact on individual staff members’ performance and, in all cases to date, the police have, to our knowledge, decided not to recommend prosecution of individuals.

In our view it is vital that the police have easier and routine access to experts who can describe the realities of modern NHS healthcare provision, and to experts in patient safety, human error and ‘error wisdom’, to allow the police to quickly come to a view about the actions of individuals.

Medical Profession

Press should not be allowed to release name or photograph until charges brought or person taken to court. Staff interviewed under caution should receive anonymity as interview under caution does not equate to guilt but in public mind it does and they may never be able to work as healthcare professional again.

in my personal experience "our" coroner deals with these cases in and extremely supportive way for the family

Positive: In our trust all the outcomes of coroners are sent back to all clinical staff with the verdict and a small paragraph about the learning.

However in direct contrast: I have given evidence at coroners inquests as a clinician involved in the case, and also as a serious incident investigator. The outcomes of coroners inquests should be shared more robustly with clinical teams, for example, the coroners office should send a written summary to the hospital for review in clinical governance sessions. In my Trust, we never hear the outcome of coroners inquests unless we have attended personally ourselves.

The coronial process lacks consistency

Usually very good, I feel coroners protect doctors to a certain extent albeit some them are not adequately trained now medically to an appropriate level maybe due to complexity of superspecialisation.
The role of expert witnesses in inquests, however, must be investigated. In the Bawa Garba case, the arguments used against her by the expert witness were poorly balanced and unsupportable, and yet were the reason that the case was once more referred to the police. The recent treatment of Dr Bawa-Garba was cruel and unnecessary. The coroner dealt with the case in a disposable manner by playing to the gallery and press and trying to make political points scoring. This adversarial environment will not lead to learning as all get lawyered up. Listen to commentary on social media. It’s an accurate reflection of the issues.

The police and prosecution team need to access proper clinical advice and have that advice put before the court in an accessible manner

The police are fairly often involved with an inpatient suicide / mental health death. They are frightening and unhelpful. Processes are slow non transparent and feel arbitrary.

Police turning up to interview clinicians without warning can be very distressing. Certainly in my case this was the first I heard there was a problem and again no communication or support from my trust

this is not a standardised process. I do not know if we have data on the frequency of referral in different areas - I suspect not and this should be instituted. there could be research into the decision-making processes eg discussion of standard cases, analysis of interviews with participants. there should be national standards for training in this area and the process should be monitored

Often heavily dependent on reports from the referring hospital, with reluctance to use external experts, and often treating the pathologist as the all-purpose expert witness. Coroners are under pressure to do things as cheaply as possible, and staff cuts often mean the Coroner's office is chaotic.

Major problems in this area. Due to the coroners whom have no medical qualifications...

I have been involved in 3 cases of suicide as a trainee psychiatrist where there was an inquest. I prepared a statement in one case and gave evidence in the other. In the 3rd, the consultant took on that role. I was fortunate in all cases to have her, guidance and support from my consultant-practically and emotionally. I have also appeared as an independent expert witness in 2 inquests in 2 different coroner's courts. In these cases I sat in the court and heard all the evidence. In one I received previous information but in the other I was asked to give evidence and comment, based on the evidence I heard. In both cases I know I was helpful in providing an explanation. I was thanked both by the professionals and the family

- It took approximately 3 years before the police advised there was no evidence of criminality. - The trust didn't tell me of the result until the coroner's pre-inquest hearing (even then, it came from the trust solicitor and not from the senior management team of the trust). - The initial scoping report completed by an independent doctor was questioned by the complainant, which went back to the independent doctor and led to a second report - this is not independent. - The complainant disagreed with the report and so the police commissioned a further report - The police told me and the trust nothing during the investigation.
Initially, when I qualified, clinicians could get away with outrageous behaviour and I saw one consultant surgeon whose definitely negligent action had been reported by a surgeon in a nearby hospital, simply shouting at the coroner’s officer "How dare you question my practice' and the officer went away,, the case was never heard of again.

My dealings with the coroner have always been fair and the hearings conducted in a fair and proper manner. The one hearing where the relatives were significantly unhappy was extremely well done. Lawyers for the relatives were allowed to ask their questions directly of myself and my answers were perceived by them and their lawyers as fair and honest, answering all their concerns. The only problem with that hearing was the barrister sent on the insistence of the MDU who turned out to be a dangerously ignorant man, but fortunately was ignored by the much more knowledgeable solicitors for the relatives. On this occasion an error had been made by a junior but in a situation which suddenly arose in a circumstance for which he had not been trained or had experience, but had to act very quickly and without the best equipment. The relatives understood when it was carefully explained to them with compassion. The MDU barrister took a very different and much more "protectionist" and non conciliatory response which would almost certainly have resulted in litigation, but as I said above, he was ignored and my answers were honest, admitting the mistake and explaining how it happened. I did inform the MDU of the very bad experience I had of their barrister!

**Adversarial and lengthy**

One case in 2005 of inadvertant disconnection of patient from a breathing machine. I was a supervising consultant but was engaged elsewhere. The doctors who were directly involved were criminalised very quickly. It was over a year for the investigation and the coronors inquest was very much a trial (felt like one). The doctors moved to other hospitals (or not) and had to pay for legal support from their own pockets which left them in financial hardship.

Our coroner seems to take on the role of a prosecutor, hunting out negligence, rather than the defined role read at the start of every inquest

What do we learn? Honesty, integrity and openness are recognised by relatives.

We can learn:

feedback from the process as part of education

- it takes too long
- Communication between the police/trust/individuals concerned is not happening
- The complainant has a voice and can alter the initial scoping reports making them not truly independent
- It's frightful for the clinician involved and the lack of communication, the trust not giving any assurances and the lawyers not giving any assurances that it won't go any further leads to despair. ‘The process was distressing and traumatic for all parties.’
I have had a great deal of experience. The process is slow and in terms of future safety tends to focus on bigger themes, whereas it is often the detail that is most important.

I believe coroners have too much power with little chance of those who feel wronged having any redress. The coronial system is many centuries old and needs looking at. I believe this was considered some years ago but alas, abandoned.

The role of the coroner is supposed to be to answer the 4 questions laid down including how the person died. In my experience what actually happens is that the coroner carries out a case review, critiquing all aspects of the medical and nursing care. The latest fashion is to provide an open forum for relatives to ask questions in court.

Parent expectations have changed cf Charlie gard and recent case in Liverpool. Social media has been a driver as well. Coroner might say "natural causes" BUT once parents get the SI report (with the finger pointing) there is nothing to stop them going to:

- press
- police
- GMC
- CPS
- social media

They may not succeed BUT they can make life hell for the doctor. Where is the control?

**Academic**

Oliver Quick, University of Bristol

I have limited knowledge of individual cases which have been referred to the police. However, it is clear that whilst such cases are invariably complex and rely on the evidence of very busy people, that such investigations tend to take a long time to conclude. Such delay does not serve the interests of anyone involved with such cases.

**Scotland:**

I have reported many deaths to the procurator fiscal, some after falls or unexpected cardiac arrests. None had suspicion of negligence. I have always found the PFs very helpful and make it a very "normal" (low-stress) process.

Coronial investigations and Fatal Accident Inquiries are usually robust, but are time consuming and will take the clinicians involved out of the clinical environment for significant periods of time – in preparation of reports, meetings about the inquest and the inquest itself.

Reports from Fatal Accident Inquiries need to be sense checked and this is now happening in Scotland. The Procurator Fiscal and Crown Legal system seem reluctant to pursue doctors for clinical issues.
In my experience fatal accident Inquiries are exceedingly superficial. If reports are written critical of the doctors concerned they are suppressed by the Defence Unions.

Verbal referral to the procurator fiscal in Scotland in my experience leads to my giving an explanation for an unexpected death, the patients past history and recent clinical history and whether, given the circumstances if I was willing to issue a death certificate. My anecdotal impression is then the procurator fiscal service in Scotland is overloaded and understaffed. Where the circumstances and past history given by the Dr suggest a cause of death and if the doctor is willing to issue a certificate, I believe permission is very likely to be granted without further evidence.

A number of cases have been referred to the fiscal. Some because the family were unhappy, and it seemed best to learn all one could about the diagnosis. One because there was something that went wrong. Some because we had no idea of diagnosis when patient died soon after admission. One thing that strikes me is the lack of contact with the "referring" physician, or physician "in charge". After contacting the fiscal and giving them the story, if they decide to "take over", the notes disappear, and you are never informed of progress - or, indeed the result. On at least one occasion I never did obtain PM results in a patient where the fiscal has been informed because the diagnosis was uncertain. I am not sure of the thinking behind this.

I have had to provide statements to procurator fiscal and knowing there background is sometimes helpful as not all have a medical background and this can affect the way a report is structured.

I (or one of my team) report fatalities due to trauma regularly but these are expected deaths usually due to severe trauma so these are straightforward and are dealt with easily. In 20 years I have had an experience of reporting one on-table operating death and one death within 24hrs of surgery to the fiscal. I was personally responsible for both deaths. I reported the death to the fiscal office myself in both cases and informed the hospital management. The fiscal office were helpful and efficient and investigated quickly. The hospital followed up with investigations of its own and interviewed many staff involved. I spoke to the relatives myself immediately after surgery and again a few weeks after surgery with managers and nursing staff present. In these cases they were high risk cases with a high chance of death that had been discussed pre-operatively. It was do or die surgery in one case in a very premature baby. The other was a brain tumour case. I found it very stressful and unpleasant even although I knew that I was not really to blame and no mistakes had been made. Goodness knows how doctors feel when they know a mistake has been responsible for a death. it must be awful. I think we need to have a compassionate investigatory system that recognised that staff will be under a lot of pressure.

2 FAIs which there was no follow-up and I was told at one FAI by the deceased child's relatives that I was the only one who understood the case and told the truth. The doctor was not criticised , never mind suspended.

The police in highland have successfully stopped treating every death as a crime scene. I think reporting could be made simpler.
**Systems/improvement regulator**

Healthcare Improvement Scotland

(HIS) has agreed with the Procurator Fiscal to share the learning points from particular reviews into deaths more widely across NHS Scotland, in order to facilitate national learning and improvement. The aim of this process\(^3\) is to ensure that learning from death investigations is shared in the most efficient and effective way possible, and ensuring that this is done in collaboration with the NHS board in which the review took place. Please see the following link for the process:

\[\text{http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4089731/0d5b7acc-189f-410f-96c9-3cb6cde4a444.pdf}\]
Question 31. To what extent does an inquest or fatal accident inquiry process draw on or rely on the evidence gathered in the post incident investigation by the hospital/trust/board or other healthcare setting?

There were 380 responses to this question online. There were mixed views in response to this question, but overall there was recognition that the serious incident report is a relevant part of the evidence that should be considered (not relied upon) by coroners, notwithstanding the potential for bias of investigations and the fact that they will need to consider and scrutinise other relevant evidence as well.

Patients and Families

One family member recounts their experience from 2005, saying they have ‘...no idea whether it [the serious incident report] was relied upon because the verdict was read out in the coroner’s court in about five minutes. Although I was permitted to see the medical records of the deceased, none of the family present were permitted to address the coroner or the party who read out evidence.’

Another family member believes that the ‘...inquest relies heavily on the evidence gathered by internal investigators during an investigation. In our case no independent interviews were ever carried out by any other bodies and the interviews made by the staff responsible for our son’s death during the internal investigation were called into evidence during the inquest. The findings of events during the internal investigation into the drug error were used as fact by the coroner when making a decision on cause of death. For this reason we feel it is vital that the interviews are conducted by a totally independent body.’

Similarly another family thinks ‘...totally.’ They say that ‘...The Coroner was called to give evidence at the public inquiry hearings [hyponatremia related deaths NI]. His evidence was that he was deeply concerned about what he has read and heard with regard to the hospital post incident investigation into my daughter’s death. The Coroner had been intentionally misled by doctors under oath and also by improper evidence gathering by the Health Trust. The public inquiry finding is that the cause of death is wrong.’

Medical profession

Whilst there was mixed views demonstrated in responses to this question and a number said they don’t know or words to that effect, most medical professional respondents said that the serious incident report (SI report) is relied on extensively (the word ‘heavily’ was used 13 times and ‘a lot’ 11 times) and that coroners routinely ask for SI reports and transcripts of interviews that lead to the reports preparation. Some say that the SI reports ‘...are now routinely prepared with the coroner as an audience in mind.’

NHS Improvement advise that ‘...Over time, the Serious Incident process appears to have led to a reliance on the NHS-led safety investigation process as a means of responding to all types of issues, including those associated with litigation, a coroner’s inquest or professional competency/fitness to practise.’ They go on to warn that ‘...As a result, safety investigations often make inappropriate judgements about predictability, preventability and/or cause of death, rather than focusing on the problems in care and how and why these occurred... this
issue is undermining the quality of safety investigations in the NHS and we need to ensure that the scope/purpose of safety investigation preserved.’

One respondent says that ‘...by the time police involved, many weeks may have passed and memory less reliable, evidence destroyed e.g. bag of fluids’, which suggests that they think this is why they rely so heavily on SI reports.

According to the Association of Surgeons of GB&NI ‘the coronial process relies heavily on the information obtained in SIARC/SUI investigations...’ The report of the investigation frequently provides a ‘template’ for the line of investigation pursued by the coroner.

This was echoed by BMA which wrote that the staff and local investigation materials will usually be used in both sets of procedures.

Some who say that the coroner relies heavily on SI reports say however that ‘...the Coroner will frequently scrutinise this and seek clarification. They are at liberty to adjourn to seek further evidence as to whether the submitted evidence is excessively biased.’

Conversely, some respondents say there is minimal or not very much reliance or consideration of the SI report and one respondent says they been ‘told our coroner does not want to see or be influenced by the hospital SI enquiry... It is his court and he wants to weigh up the evidence himself.’ We are also reminded that medical records and evidence from relatives and other relevant parties, are also ‘clearly taken into account.’

The Royal College of Pathologists said, pithily that this was ‘variable’. Similarly, the Medical Schools Council said it ‘varied’. And again, the Royal College of Anaesthetists said ‘very variable’ but added that in its view coroners should consider the evidence gathered in local investigations.

On the other hand, the Royal College of Physicians and Surgeons Glasgow responded more positively that it was ‘often used’.

Dr Jenny Vaughan, (and a couple of other respondents drawing on the case of Dr Bawa-Garba) argued that the SI report is relied upon ‘Insufficiently.’ Dr Vaughan adds that ‘...A Coroner’s inquest should not take place without a fully independent SUI being made available. The CPS should not charge any individual medical defendants without taking into account the SUI report. There should be an approved list of documents which they routinely ask for when they are investigating a case and so should the coroner. I have spoken to the CPS already about this and I believe they are open to the idea... Hospital SUIs themselves should also be performed in a standardised way.’ Dr Vaughan calls on the review to look into this suggestion for an approved list of documents.

MDDUS said that coroners ‘routinely’ consider such reports but ‘rely’ on them to ‘varying extents’. It noted that there is a lack of uniformity of procedures and approaches between different regions. It also pointed to the dubious quality of Trust investigations which it said are ‘seldom truly impartial and often place undue emphasis on the acts or omissions of individuals.’ They also highlight that the focus of hospital investigations will, in most cases, be different to the focus of a Coroner, particularly in respect of causation. They say that their use is limited and the ‘main utility of these reports for Coroners is likely to be in
assessing whether or not a Report to Prevent Future Deaths is required; or whether any issues have already been suitably addressed.’

MDU also cautioned against reliance on the local investigations: ‘in too many cases we believe the incident reports [coroners] receive from trusts are incomplete and/or inaccurate and/or misleading.’

Similarly many individual respondents criticised that coroners relying on SI reports is ‘flawed’ as ‘a Trust may have an incentive to prevent evidence about unsafe staffing / systems failings being made public.’ Saying that sometimes ‘...it would be in a trust’s interests for an individual doctor or nurse to take the blame as they are easier to resolve /remove’. Another claims ‘the hospital covers their ass.’

One medical professional argues that in their ‘...experience the old medical coroners were very good at finding things that the hospital was trying to hide. The legal coroners do not pick on issues not covered in the report. I think that it is much better to have a medically trained coroner. If not then the coroner should access to and USE have independent medical advice PRIOR to the inquest.’

A Medical Director tells us that ‘...The SI report author and the medical director often have to attend to give evidence particularly as it bears on issues related to the prevention of future deaths. Coroners and legal teams may also instruct experts.’ They share their experience where they have ‘...have participated in inquests where there were three separate expert opinions in addition to the SI report author. None of them agreed.’

One respondent says ‘...It should be an independent team that gets the evidence. It is too open to bias. All evidence issued against doctors so there is no protection. I think the healthcare setting will be subjective and try and pass blame on an individual. Independent investigation is important.’ But do not detail who or which organisation the ‘independent team’ should be from.

Another claims that ‘...If there is conflicting evidence then a more in depth investigation is required. I can see how self-reported evidence may not have the credibility in the eyes of the public that independently obtained evidence would have, but the latter would be a costly process and justification is required when explaining the cost to the public.’

One respondent is critical that ‘...the evidence presented at the inquest, was often not available to the clinicians during the case, due to process or confidentiality issues.’ Another claims that ‘...the complainant can decide what goes into the bundle and the individual clinician has no say.’

Two medical professionals share their personal experiences of the police and the coroners

- ‘The notes taken by the police officers are very basic and thinking back I did not find that they asked very probing questions.’
- ‘In my case the evidence and investigation from the trust was poor quality, the coroner followed an inappropriately adversarial model and was fixated on attributing causation where it did not exist.’

Scotland
DAUK wrote that the inquest of a FAI may contain the outcomes of local investigations and staff involved are likely to have submitted statements for a local investigation.

A more detailed account of proceedings in Scotland came from the Law Society of Scotland. It noted that the PF’s investigation is independent. ‘It does not rely solely on material gathered because of the initial review of the hospital by the NHS...typically the police will be instructed to take statements from all material witnesses and to seize documents and items that are relevant to the investigation. Whilst evidence gathered by the NHS will form part of the investigation by the procurator fiscal, that forms part of the information considered in deciding about the case as opposed to evidence from the hospital...’

An individual respondent says that ‘...the FAI will only rely on evidence called and presented by representative counsel which includes the Procurator Fiscal Service.’

Medical and Dental Defence Union of Scotland say they ‘understand that internal reports are also considered by COPFS in Scotland, and we are aware that these reports may feature as productions in Fatal Accident Inquiries.’

**Other comments about the coronial proceedings**

**Lessons learned or learning dissemination from coronial proceedings?**

The purpose of the Coroner’s Court is to investigate the cause of death. This can be very helpful in identifying 'lessons to be learned' and 'the Coroner can now legally enforce change on organisations.' However respondents also say that ‘...the process doesn't always identify all the learning that might be possible from a particular case because of the limitations of its purpose.’

We are reminded that ‘...Healthcare staff worry hugely about their attendance at coroners court as they worry it is the first step towards them being struck off or sent to jail.’
Question 32. What is the role of independent medical expert evidence in inquest or fatal accident inquiry processes?

There were 370 responses to this question online.

Answers to this question were mainly factual, for example some respondents simply point to Part 35 of the Civil Procedure Rules on ‘experts and assessors’. A number of respondents describe their role to ‘...Provide objective appraisal and interpretation of the evidence available.’ Or ‘...informing legal professionals’ of areas outside of their knowledge or expertise.

There were a number or recurrent themes identified in responses to previous questions about the role of independent medical expert evidence in local investigations, in particular issues around independence, training and accreditation.

The ‘role’ of independent medical expert evidence

A family member or patient says their role is to... ‘To provide an objective, non-emotive professional opinion and will decide whether other doctors in the same situation would have made the same decisions.’ Another says... ‘To provide expertise in specific areas of the body and the effects certain drugs or illnesses may have on them.’

Another holds the view that they are... ‘to provide clarity why the patient had died, but... the results of microbiologist are the most important. It shows clearly if the patient had capacity to recover, which lead to only one conclusion GROSS NEGLECT!’

All of the other family member or patient respondents who replied said that they didn’t know or were not sure.

A legal professional tells us that ‘...The role of an independent medical expert in an inquest does not differ manifestly from the same role in the civil or criminal jurisdictions. The expert assists the Coroner in respect of matters that are beyond the knowledge or understanding of the court.’

The Doctors’ Association UK (DAUK) wrote that the coroner will ask the medical expert to help inform the inquest and comment on actions or omissions contributing towards a death.

Faculty of Pharmaceutical Medicine say that ‘...the independent medical expert is the key evaluator of the internal investigation. The importance of the role in checking and challenging the internal report is critical. The value is that the internal investigation, whilst it may point toward the blame of a person or a system, it can be "validated" by the external expert, who as with the members of the hospital trust would exhibit integrity, openness and probity, but would also be independent.’

The Medical Schools Council (MSC) said expert witnesses are there to ‘provide impartial, evidence based advice...’ The Royal College of Physicians and Surgeons of Glasgow (RCP&S Glasgow) took the same view.

Association of Surgeons of GB&NI wrote that medical expert evidence ‘may advise the coroner as to the adequacy of the local investigation and provide commentary as to the
actions of the clinicians concerned.’ But they go on to say that it is not the role of experts to opine on whether criminal or civil proceedings should ensue.

**Issues with medical expert evidence in coronial proceedings**

The Medical and Dental Defence Union of Scotland (MDDUS) highlighted an issue with medical witnesses as to the ‘fact’ of an event sometimes being used inappropriately as ‘quasi-experts’ within proceedings. They also write that this causes them concern because:

'First, it often results in expert evidence being given for the first time from the witness box, with Interested Persons (IPs) being unaware of what opinion will be proffered; second, it is highly unlikely that such evidence will be wholly impartial since the witness concerned must have had some involvement in the deceased’s care; third, witnesses in this scenario are seldom trained in medico-legal work and are not, therefore, necessarily aware of the appropriate legal tests to be applied; and fourth, it can place the witness in an extremely uncomfortable position if they are asked to comment on their colleagues’ acts.’

They also highlight that in their view...‘there is very little uniformity in the Coronal system in England and Wales and MDDUS has found that the use of independent medical experts in inquests varies. Medically qualified tend, for obvious reasons, to obtain independent expert evidence less frequently; whereas Coroners who are legally but not medically qualified are more reliant on expert opinion. In our experience, expert evidence is of particular use when there are issues of medical causation to be addressed; or when there is a conflict of opinion which the Coroner will need to determine...Given that Sheriffs presiding at Fatal Accident Inquiries in Scotland are not medically-qualified, it is our experience that medical opinion will be sought by COPFS.’

The Law Society of Scotland make the additional point that...‘expert evidence is never determinative and can be rejected.’

**Lack of training and accreditation**

The Hospital Consultants and Specialists Association argue that ‘...While independent medical expert evidence does have a role in assisting investigators to make a conclusion, it equally brings with it uncertainties as there is no proper training or system of accreditation to ensure that medical “experts” are indeed experts.’

An individual respondent adds that ‘cultural sensitivity training should be provided to the independent medical experts to assist them to address any unconscious bias.’

Another shares their experience saying ‘...medical experts, and the credence given to them by the coroner, is variable. I have encountered an expert who wasn’t qualified to give a view in the particular case, but who was given credence by the coroner. It doesn’t look to me as if there are enough checks in the system to deal with this type of situation.’

**Expert’s opinions are ‘bought’**

Another anonymous submission from the legal profession says ‘...they are paid to provide a view. When money and medicine mix, disaster cannot be far away.’
Some medical professionals responding to this question also are of the view that expert opinions are ‘bought’ to support the position of those instructing them (as opposed to their duty to the court to provide objective and impartial opinions). Others say the role of medical expert evidence in inquests is... ‘Significant, but there is not a list of such experts so again word of mouth. Very variable if expertise listened to by jury/coroner - depends on emotions... It is not unknown to have contradictory results between different experts... and conflict of interests do happen.’

One respondent queries whether it would be better for experts to be appointed by the courts.

**Unrealistic opinions by specialists and lack of recent, relevant clinical experience**

Nick Ross, a broadcaster and journalist told the review that he has... ‘serious reservations about ALL expert evidence in court. I have worked on the periphery of the criminal justice system and the closer my involvement the more I have become disillusioned by its ability to assess evidence of anything other than legal niceties. The process of scientific challenge in courts can sometimes be risible when compared to the scientific method. However, I am struck by another feature of so-called ‘expert' evidence where it affects medicine. A decision made hurriedly by a non-expert can be challenged at leisure by a specialist, as happened in the Bawa-Garba case. A jury may be given a clear steer of what, to a hugely experienced consultant, seems a ‘barn door’ error, whereas less expert doctors might have given the court a very different - and perhaps more realistic – impression’.

Similarly, a number of individual respondents shared the view that the medical expert ‘...usually gives a narrow view based on their usual narrow practice which is not generalisable to the situation which is being judged.’ Another adds their perception that ‘...independent medical expert witnesses do not seem to conduct themselves in an evidence-based manner and may place excessive emphasis on ideal practice rather than real-world practice.’

Another goes further and shares their view that ‘...unfortunately many 'experts' are themselves poor at communication being rather arrogant and blindly believing entirely in their opinion without being able to be nuanced... many such experts have a deep but often hidden dislike of other specialists, hospitals etc.’

A number of respondents call for independent medical experts to hold a licence to practise and to have recent clinical experience in the relevant field to that of the individual in question.

**‘Truly independent’**

A number of respondents queried the definition of ‘independent’ and also reiterated that the expert does need to be ‘truly independent.’ Although a couple note that this is sometimes ‘...difficult to achieve particularly in smaller specialisations and magnified if the situation involves a high profile professional - consider having international experts in high profile matters to ensure true independence.’
Another calls for independent evidence that encompasses ‘...integrity, openness and complete honesty with compassion for the feelings of the aggrieved party are essential.’

**Available pool of experts**

We are told that ‘the number of independent medical experts is often very limited’ and ‘that solicitors can find it extremely difficult to identify a doctor who is prepared to compile an independent report... the judicial process puts a lot of doctors off acting as expert witnesses, as the process can be very upsetting and the expert witness often emerges feeling that they are the person on the dock, rather than an important advisor on highly technical issues... the whole process of finding expert witnesses needs review.’

**Rarely used**

Some respondents say independent medical experts are rarely or often not used (‘certainly not enough’) in coronial proceedings. One medical professionals says that ...‘the pathologist is often pressured to be the expert witness.’

**Numerous and conflicting expert opinions in inquests**

A couple of respondents called for two or more experts to ensure balance of opinions however, others highlighted that there can often be several experts and legal representation in inquests which in itself is not helpful. One medical director shares their experience of a case of a ‘failure to use a ventilator correctly, resulting in patient death from hypoxia brain damage.’ This MD says that ‘the Trust, the trainee, the anaesthetic machine manufacturer and the family all had separate legal representation in the Court. [There was] A lot of legal discussion around the scope of the inquest, presence or absence of a jury, etc created a huge amount of angst, and made the inquest feel like a trial rather than an investigation to establish facts. This cannot continue. Each “side” called their own independent medical expert, None of the experts agreed so we had four different opinions about what did/didn’t happen, what could/should have been done differently, and where responsibility for the death lay. It was chaotic and distressing for all involved.’
**Question 33. How are independent experts selected, instructed and their opinions used? Is access to appropriate expertise always available? Do they have training in unconscious bias?**

There were 358 responses to this question online.

As we saw in responses to previous questions on medical experts, there was widespread concern expressed about the selection, use of and ‘deficiencies’ of/quality of medical expert advice in (coronial) proceedings and expert’s lack of independence.

Most patients or family members did not respond to this question, however one family member highlights the following issue ‘…It is not unknown to have contradictory results between different experts.’

**How are independent experts selected?**

We are repeatedly told by respondents that the process of selection is not clear (lacking transparency), variable, and does not equate with quality or appropriateness, with respondents saying they are instructed:

- depending upon availability
- by pre-existing links with legal firms. Or similarly, ‘there are a group of doctors whom barristers approach because they know such individuals are interested in giving expert reports’
- from pool of self-appointed candidates
- based on factors such as publications more than number of cases personally handled
- may be based on price and financial motivation of the ‘expert’
- reputation (regardless of relevance) or who knows them
- depending on their opinion on the area in question in the case (if favourable to the instructing side).

We are advised that not only is the process of selection not clear, ‘…but does not work well (in the Bawa Garba case, the expert witnesses both at the coroner’s inquest and for the prosecution at the trial were, totally inappropriately, paediatric intensivists). It should be possible to define appropriate expert witnesses, but no good effective machinery to achieve this seems to exist.’

A legal professional shares their experience that ‘...regrettably, there is a great deal of inconsistency in the instruction of experts. Some Coroners invite submissions from Interested Persons (IPs) as to the identity of an appropriate expert and also submissions about the terms and content of the letter of instruction...there can be a danger that a Coroner (and particularly an inexperienced Coroner or one who lacks requisite knowledge) can rely too heavily on the opinion of an expert, particularly given the inquisitorial, as opposed to adversarial, nature of the proceedings. However, other Coroners are less willing to involve the IPs and so instruct experts on the basis of their subjective position or understanding of a given case. In cases where IPs have not been afforded the opportunity
to contribute to the process of instructing an expert it can be necessary to instruct an expert for an opinion on a particular IP’s position in a case. It can often prove difficult to persuade a Coroner to admit additional expert evidence beyond that obtained by the Coroner.’

Medical and Dental Defence Union of Scotland (MDDUS) also say that ‘practice varies...some Coroners seek expert recommendations from one another; and some Coroners ask IPs for suggestions; or propose several experts and canvass views...Coroner-appointed experts is varied; and it is not uncommon to receive an expert report which is muddled and/or fails to address the issues in question...It has also been known for legally-trained Coroners to appoint an expert in the wrong speciality and/or put questions to an expert which fall out with their expertise. Whilst we would always hope that an expert will immediately flag this and decline to answer questions, we have had experiences where this has not been the case...As far as the practical instruction of experts is concerned, we again have a range of experiences. Some Coroners simply instruct their expert without recourse to the IPs; and then circulate reports as part of their disclosure. Other Coroners will circulate a proposed list of questions for the expert to address and/or will ask IPs to make submissions regarding questions...best practice would be for the Coroner to be the driving force behind the instruction; but with scope for IPs to make representations if necessary. This will hopefully prevent any one IP from becoming unduly influential in the instruction of the expert; and will ensure that the expert is properly directed to provide evidence which will assist the Coroner in answering the requisite questions.’

We are of the view that in circumstances where the expert evidence is unclear, or an IP takes issue with the opinion in any way, the expert should be available to give oral evidence. Availability should be, but is not always, elicited at the time of instruction. We have had experiences of inquests being postponed, sometimes for protracted periods, because of the unavailability of an appointed expert on the original dates set.’

Lack of confidence in the independence of witnesses was also expressed by individual respondents. A respondent wrote ‘...There is no scrutiny about who may give evidence as an expert witness...’ The expertise of the witness is chosen by the legal team for either side who may not always be qualified to assess that expertise.’

The Royal College of Pathologists felt that the selection of experts tended to be because they are known to one of the investigation team, and are therefore not entirely independent. Similarly, the Royal College of Psychiatrists (Scotland) wrote that ‘We do not presently have a robust selection process’.

Similarly the Association of Anaesthetists GBI say that ‘...Too often medical experts are chosen because of availability, reputation or word-of-mouth recommendation. For example, the availability of retired colleagues is often much ‘better’ than those in current practice, yet their knowledge and experience of contemporary practice may be less.’

The Medical Schools Council seemed to endorse this impression about the slightly random selection process saying that there is ‘no standard approach’ (same phrase used by Royal College of Physicians and Surgeons Glasgow). They also noted practical challenges in that
suitable experts ‘are not always available’. And like other commentators, they pointed to the lack of ‘consistent training’.

Access to suitable expertise was also something picked up by the Royal College of General Practitioners (RCGP). It wrote that coroners ‘should have access to a medical expert or panel of experts with experience in the specialty under consideration’. This should also apply to the CPS.

**Independence/impartiality?**

BMA said that the role of experts was to provide ‘objective, unbiased opinion on matters within their expertise’. However, it believed that more should be done to ensure their impartiality and objectivity. Linked to this BMA highlighted the risks of confirmation bias, contextual bias, and unintentional stereotype bias, arguing that every expert should receive training in how to guard against cognitive bias.

**Unconscious bias training?**

Most respondents told us that there is no requirement for an expert witness to be trained in unconscious bias, and this is indeed very unlikely to be the case. MDDUS advise that ‘...whilst it is not currently the case, we are of the view that Coroners should ensure that their experts have suitable training and experience in acting as an expert witness, to include but not limited to training on unconscious bias, before instructing them.’

Like others such as BMA, RCP felt that expert witnesses need to receive training in certain areas, such as unconscious bias. RCP also pointed to the importance of expert evidence being collected as early as possible to inform decisions about whether or not to prosecute.

Some respondents highlight that not only is there no unconscious bias training, there is no training at all for experts, although they also remind us that ‘training doesn’t confer ability.’

The Association of Anaesthetists GBI believe that ‘...A medical expert should be a subject matter expert, with training or significant experience in providing independent, unbiased opinion. They need to understand both the medical and legal issues...’

One respondent queries ‘...I wonder if judges (including coroners have had any training in the interpretation of medical expertise?’

Indeed MDDUS say it would ‘...be helpful to ensure that all Coroners have appropriate training in selecting and instructing experts.’

**Potential for assurance mechanisms (standards, selection criteria, accreditation etc)**

Only one respondent indicated their belief that ‘there is training and a register of suitable experts now.’

Like DAUK individual respondents see a role for colleges in vetting and regulating, saying that specialty associations would be well placed to help with this. One respondent worries that surgeons who are retired and out of touch end up acting as experts, and concludes that ‘...I hope that your review will include the suggestion that the medicolegal experts
should be required to fulfil certain criteria and a strong recommendation that the legal process subscribes to these criteria. Stuart Irvine (NES) noted the lack of any qualification requirement to become an expert witness.

This was echoed in the response from the Royal College of Physicians (RCP) which wrote that for ‘expert witnesses to be independent, they must meet a set of agreed criteria and be appointed by an agreed process’.

The Academy of Medical Royal Colleges (AoMRC) wrote of the concern at what appears to be variation in practice and standards and how the police and CPS access clinical expertise on which to make decisions about prosecutions. They refer to ‘questions about access to clinical expert advice, consistency and standards of investigations’. They also mention ‘concern over the standards of expert witnesses in some cases and over a lack of common standards and expectations amongst both witness and in the commissioning of witnesses...’

AoMRC identified the following issues:

- How to ensure the expert is up to speed in current practice
- How to ensure the expert understands the context – a specialised clinical academic may not understand the reality of frontline clinical practice.
- Or, in historical cases, the expert may not appreciate what was established practice at the time.
- Where on the spectrum of opinion a particular expert sits. It might be that the relevant college can provide a view.
- Self-declaration is needed by experts about the scope of their practice.
- The role of Medical Examiners in providing expertise at an early stage of an investigation [a good thing]

There is no enthusiasm among colleges to take on any sort of role in regulating medical experts or holding a register of experts. Colleges had wanted a guidance document produced setting out expectations regarding expert witnesses, but apparently the coroner service declined to support this initiative.

AoMRC noted its support for the Williams Review recommendations and that the Academy will be drawing up a framework of standards and good practice and developing training.

The British International Doctors' Association recommended the establishment of a panel of ‘medical expert advisors’ who are familiar with the NHS to advise coroners.

Interestingly, DAUK goes on to say that there should be ‘independent regulation and accountability’ of expert witnesses to their respective medical colleges should be ‘mandatory’, as should formal training. This contrasts with the AoMRC response which indicated that the colleges had no wish to take on a regulatory role in this area.

Like a number of commentators, RCGP referred to the need for revalidation to include the full scope of a doctor’s practice, including any work as an expert witness.
Many of the themes set out above were explored in the MPS response. On training, it wrote that acquiring the skill set to be an expert witness should be part of training for consultants and GPs. Expert witnesses should also receive training to understand their duties to the court. Having the skills and being prepared to act as an expert witness should be seen as an essential component of the role of an established doctor. But there was also a role for legal counsel in exercising due diligence in selecting the appropriate experts. MPS concluded that AoMRC should have a greater role in promoting standards among expert witnesses – something endorsed by the Williams Review.

**Appropriateness of the ‘expertise’**

As we have seen as a recurrent theme in previous responses, respondents again call into question whether appropriate experts, with recent and relevant clinical experience are selected and suggest that ‘...there needs to be a complete re-think on the appropriateness of medical expert evidence, which is often effectively inexpert. Medical experts should be wholly independent and working in the same specialty / sub-specialty and in a similar environment as the doctor under investigation. There should be no undue personal gain for the expert (modest expenses only).’

There were a number of respondents who shared the view that many ‘independent medical experts have not practised on the coal face of medicine for many years.’

**Financial motivation in providing evidence**

Similarly other respondents reiterate their beliefs about the financial motivation of some experts, saying for example ‘...There are considerable fees for such reports and only a small proportion of doctors would prefer to spend their time earning their money in this way rather than making a bigger contribution to patient care through the NHS. It could be argued that a financial motive to do such work may result in the people producing the reports being unrepresentative of the profession generally and perhaps of being less altruistic than the majority of doctors. That may be worth investigating because such doctors may be more vulnerable to unconscious bias than the majority.’

**Pool of experts available**

A legal professional advises that in their experience ‘...access to appropriate expertise is generally always available. The difficulty is often in persuading a Coroner that an expert is suitably qualified to offer the required opinion (or not).’

However, we are told by a few respondents that finding appropriate and independent experts can be difficult, ‘particularly with increasing sub-specialisation.’ On medical professional tells us that in their ‘...specialty (OMFS) there are only about 300 consultants in the UK. There are at least 10 sub-specialty areas within OMFS which means that on average there will be a pool of about 30, of which only a small proportion will undertake medico-legal work. It is therefore almost impossible to achieve a situation where the possibility of sub-conscious bias is completely avoided.’

**Difficulties with selection of independent medical experts**
One respondent who tells us they act as a medical expert says ‘...The hospital or clinicians being investigated should not select but nor should the aggrieved party, as both of these could lead to bias. Having 'experts' appointed by both sides just runs into the problem of having the small boys in the sand pit kind of tussle, not likely to convince either party... The so called agreed reports can be very acrimonious. The parties get to see each other's expert reports and of course the two parties involved almost certainly believe their expert is correct and the other is an idiot so even when the court does decide the issue one party remains aggrieved. Maybe the only solution is to have committees within a legal authority whose job it is to provide experts whose only job (therefore probably retired but maybe appointed after a considerable number of years practising and leaving their clinical post) is to sit on committees evaluating the evidence in cases of possible serious negligence and in the presence of legal experts and lay people provide unbiased evaluation of the known facts. Not an easy problem to solve.’
Question 34. Do the same standards and processes for experts apply regardless of whether they are providing their opinion for a local investigation, an inquest or fatal accident inquiry process? If not, why not? For example, is there a higher level or different type of expertise or skill set required?

There were 344 responses to this question online.

The general consensus was that the same standards should apply, but that in practice they tended to be variable. A number of issues raised in responses to previous questions about independent medical expert evidence were reiterated again here.

16 respondents simply said ‘unknown’ and 14 said ‘don’t know.’

One patient or family member says ‘…they should all have the same expertise’ another claims ‘…they should all have the same expertise.’ One simply says ‘officially yes’ but does not expand further. Another says ‘…There was in my case but how I had to battle for it.’ Perhaps they mean they sought an expert with a higher level or different type of expertise or skill set, however it is unclear. Most other family members or patients did not respond to this question.

The standards and processes should be the same but aren’t in practice

Medical and Dental Defence Union of Scotland told us that ‘...the baseline standards and processes for any expert providing an opinion in the course of an investigation should be consistent; but in reality, we have observed differing standards when assisting members. In particular, experts appointed in local (NHS England or Trust) investigations are...more likely to lack training and experience in medico-legal reporting; and can misapply or indeed entirely ignore relevant legal principles. The need for objectivity and impartiality, in particular, seem to be given less emphasis in local investigations. Ideally, an expert’s expertise and knowledge etc should be commensurate with the nature of the individual investigation i.e. in more specialist and complex matters, the expert should be suitably versed in the relevant subspecialty, but still able to apply their views from a realistic perspective. We have known of investigations where a “generalist” expert has been asked to comment on a very specialised area of practice.’

Similarly, a legal professional says that there are ‘...different intentions behind local investigations (i.e. learning and risk mitigation) versus those engaged in inquest proceedings... it is not uncommon for Trusts to instruct clinicians from within the same or a neighbouring Trust to input into the learning and not as de-facto expert per se...opinions offered in such circumstances often regarded as expert independent opinions, despite a lack of independence...opinion evidence given in such circumstances often derives from a knowledgeable clinician and not one especially trained to provide expert evidence.’

There are no standards, no assurance mechanisms, standards are variable and/or the processes are not standardised

As indicated in response to Q35, the Academy of Medical Royal Colleges (AoMRC) had concerns about ‘variation in practice and standards’ surrounding expert witnesses.
A number of individuals argue that ‘...the same standards do not apply.’ For example, they say ‘...An expert for the court / GMC has specific duties and their reports have to fulfil specific functions that assist in determining legal tests. This is not the case for local SI investigations.’ Another adds that ‘...an internal investigation does not have the same resource allocation or disclosure rules compared with a legal instruction. It is therefore not likely to be as forensic. The writing of a part 35 compliant report is a very different process from the writing of an internal investigation.’

Another imagines ‘...cost is a large factor in determining the 'standard' of experts at each level of investigation! Where an inquiry could lead to criminal charges or regulatory action, clearly the expert should be of the highest standard.’ They add that the expert should have experience in giving evidence in cases of the same level of seriousness.

In relation to Scotland, another respondent similarly suspects that ‘...fatal accident enquiries would mandate a higher level of expertise given the gravity of the situation.’ Again in relation to Scotland a respondent says ‘...expert witnesses drawn for a Fatal Accident Inquiry usually have had some training regarding their role in court.’ Although they argue that ‘...this requires a significant investment in time and may end up selecting people who are not truly representative of current professional opinion.’

The Doctors Association UK (DAUK) Association of Anaesthetists GBI advise that ‘...the same standards should apply irrespective of the type of investigation being undertaken.’

DAUK add that ‘...only accredited expert witnesses who can demonstrate that they are appropriately trained, appreciate unconscious bias and an understanding of the legal implications of the case should be used on a local and national level.’

As we saw in previous responses, some individuals say there is a role for ‘...the Royal Collages and GMC together can possible provide a training scheme to guide these experts. So there could be list of qualified experts that trusts/ patients can access.’ Overall, there were a number of calls again for training for experts.

The Royal College of Pathologists wrote: ‘There are currently no standards...It is almost entirely random.’ Royal College of Psychiatrists (Scotland) wrote that ‘standards should be uniform’.

Presumably in an effort to support standards, the Royal College of General Practitioners felt that revalidation should include any work a doctor does as a medical expert/witness, while MPS argued that AoMRC should have a greater role in promoting standards amongst expert witnesses.

**There are the same standards/processes but the motivation differs**

One respondent argues that ‘...the difference is the motivation. Giving evidence to a local investigation means giving up your time for free. Giving evidence to an inquiry will usually mean being paid at a considerable premium compared to working in the NHS. The motives of those giving evidence to an inquiry may mean that they are less intrinsically suited to giving evidence regardless of any training they have had.’
Another adds ‘...expert witnesses are becoming more scarce. I mean - why put yourself in the firing line for little remuneration or kudos?!’

Other general comments made about expert witness evidence included:

- While an expert witness is often a specialist, there is no formal requirement for a specific skill set.
- Provision of expert opinion is time consuming and access to documentation and notes will be variable.
- I do think it unhelpful if certain independent experts always work for prosecution or defense.
- I am also concerned at certain Independent experts in tribunals who seem to have a very particular agenda, whether clinically or professionally.
- There are a few experts whose opinions can be predicted.
- See latest recommendations by the Family Justice Council on the selection of experts in the High Court Family Division.

**Question 35. Are there quality assurance processes for expert evidence at this stage, if so, what are they?**

There were 338 responses to this question online.

The almost universal response to this question was that there is no quality assurance of the work undertaken by expert witnesses. For that reason, few respondents offered any substantive comments. 16 said they ‘don’t know’, 12 said ‘no idea,’ and 14 were ‘unsure.’ A further 16 said they were not ‘aware’ or ‘unaware’ of any quality assurance (QA) processes.

Some examples of QA were:

- A member of the legal profession advises that ‘the only quality assurance process for expert medical evidence that we are familiar with concerns that relating to Forensic Pathologists instructed on behalf of the police to undertake a post-mortem examination of a suspicious death.’
- ‘Expert witness who appear in court are aware that they can themselves be sued if parties involved think that their performance was negligent.’
- ‘If an expert is poor then the coroner might not use them again.’ Or ‘HM Coroner’s appraisal of the credibility of the evidence given by the expert.’
- The MSC thought that some QA existed for local processes, (but did not elaborate and this seemed at odds with the responses from others).
- ‘The only quality assurance would be to have several experts working independently on the same evidence. If they reach the same opinion that can be seen as likely to be reliable. Where experts disagree it would be sensible to seek further opinions.’
- Although not necessarily or technically an assurance mechanism, one respondent says ‘...There are guidelines for example from the Royal College of Psychiatrists.’ They also advise that ‘the Royal Colleges should all have training accessible I have noticed that some other medical disciplines do not always emphasise the need to strive for independence-not providing a 'wanted' outcome can be hard to resist.’

BMA said it was not aware of any QA of experts, but noted that it was in the interests of experts themselves to perform well or they wouldn’t get instructed again. However they did not provide a description of what they meant by ‘perform well’ and there are perhaps negative connotations that this might bring (eg that they ‘gave a performance’ or ‘held up to questioning’ by the legal representatives or coroner, which does not necessarily equate with relevant medical expertise.)
DAUK was also unaware of any QA, but called for ‘implementation of formal quality controls, scrutinised independently and reporting back to Medical Royal Colleges.’ They also wanted the work of medical experts to be considered as part of their revalidation.

RCGP shared the view that revalidation should be a vehicle for looking at the work of those who act as expert witnesses. However, one respondent reported that this isn’t effective, they claim ‘…When I wished my work as an expert witness to be appraised (as part of revalidation) I found it almost impossible to achieve any meaningful quality assurance.’

Law Society of Scotland wrote that there are ‘few controls…Where reports deal with highly technical areas of medicine it can be hard to judge the expertise of the expert providing the report.’

Medical and Dental Defence Union of Scotland are also ‘…unaware of any form of quality assurance in Coronial / FAI proceedings. Experts tend, as far as we know, to be assessed on the basis of their CV and some Coroners (though not all) will specifically look for training in medico-legal work. In reality, however, having attended a course does not guarantee quality. We would welcome the introduction of quality assurance for experts in this forum.’
Police investigations and decisions to prosecute

Question 36. To what extent does the criminal investigation and/or prosecution process draw on or rely on the evidence gathered in the post incident investigation by the hospital/trust/board or other healthcare setting?

There were 334 responses to this question online.

Knowledge and experience of this area seemed to be mixed, leading to a spectrum of comments.

16 respondents said they ‘don’t know’, 14 said ‘unknown’, another 14 said ‘unsure’.

A couple respondents referred to responses they made to the question before about how much the inquest or Fatal Accident Inquiry (FAI) relies on the serious incident investigation.

Most family member or patient respondents did not comment on this particular question. One simply says ‘...Evidence is not thorough.’ Along a similar thread another says the ‘...NHS never admits fault, even in obvious cases, that’s why up to now no one has been prosecuted.’

Another says they don’t know because their case is currently ‘mid-process’.

The other family member who responded to this question says ‘...I want to go to the police but they are waiting on coroners directions actually so are GMC but it is taking too long! The trust have closed up shop re my case there wasn’t an investigation just a review! Cover up.’

Heavily or extensively

The word ‘heavily’ was used 8 times. MSC wrote that to a ‘large extent’ the evidence of local investigations is drawn on by the criminal process.

One respondent shares their experience saying they have ‘...only been involved in such a case with the police once - we held an SUI on that occasion and this was used extensively in the subsequent hearings.’

One respondent thought, ‘more than the coroner; they are finding out what the hospital culture is like and how accurately and openly evidence is gathered.’

Considered but not ‘relied’ upon

Association of Surgeons of GB&NI wrote that evidence is available to them. One respondent says ‘...While the evidence collected by the trust will be made available to the investigation, it’s likely that the evidence of the expert witness will carry much more weight.’

The Royal College of Radiologists acknowledged that it would expect the material from local investigations to be used, but not relied on: ‘we would expect the investigation to be rerun by the police and primary source evidence reviewed.’

It should be relied upon vs should be inadmissible
A couple respondents pointed to the Bawa Garba case where they say that ‘...the investigation does not seem to have been taken into account. The internal review showed multiple system failures & concluded no single person was responsible yet Dr Bawa Garba and 2 nurses were charged with GNM. How is this even possible?’

The Royal College of Physicians and Surgeons Glasgow said that ‘post incident investigatory evidence may not be used in a criminal investigation’ but that it should be mandatory to do so.

Conversely, one respondent thought that ‘...SUI reports should not be admissible in court as the important thing is to learn from process failures, rather than to punish. This will result in the greater good.’

A legal professional shares their firm’s view, that ‘evidence gathered in the post incident investigation is only used for the context in the early stages of a police investigation: it directs the scope of the investigation and determines who should be approached for witness statements. We have rarely seen such reports being relied upon as ‘evidence’ and the Police tend to prefer undertaking their own investigations and obtaining their own statements prior to a charging decision. In terms of prosecution, the CPS do not rely upon evidence other than that which they obtain themselves. Material gathered in the course of a post incident investigation is usually disclosed to defendant as unused material – material that is not generally disclosed to the decision makers (the jury).’

Similarly NHS Improvement say that ‘...a coroner may include the findings of a Serious Incident investigation report as part of the evidence in their own report, but the terms of reference of the safety investigation and the coroner’s inquest must not be confused – that is, safety investigations should not seek to determine the cause of death. The safety investigation itself is conducted for the purposes of learning and improvement only.’

**Problem with reliance on ‘biased’ local investigations**

As we saw in response to the previous question on reliance on SUI in inquests and FAIs, a recurrent common theme here was caution on reliance on local investigations in the criminal process which we are told can be problematic if there are concerns about the quality and impartiality of the local process. An individual respondent, wrote that there was an abiding fear for doctors ‘...Say something injudicious, or admit something in a hospital inquiry and it will be used against me later.’

MDDUS said that the police or PFs will invariably obtain the untoward incident report but should not have access to the underlying evidence used for the report. They would need to undertake their own interviews and get written statements rather than rely on the local process.

BIDA didn’t directly answer any of the questions, but made a number of recommendations which touched on the issue. They called for clearer guidance for coroners, police and CPS to prevent unnecessary criminal investigations and said that GNM cases should be referred to the police only after consultation with the Chief Coroner.
DAUK was not aware of how the process worked, but felt that a ‘robustly conducted independent review into a clinical incident could accurately inform further investigation.’

**Varied approach**

The Royal College of Pathologists said that the approach varies from case to case. This was matched by BMA which mentioned the need for more consistency of approach. RCoA recorded its support for the Williams Review recommendation for an MoU between all the parties involved setting out roles and responsibilities, how they should communicate and expectations of expert witnesses.

**Evidence from the potential defendant in investigations**

Dr Jenny Vaughan believes ‘...this is a very worrying area as the fact is that anything declared by a doctor in these investigations can be used against them in a criminal court. This means that even when they don't know they might be on a manslaughter charge they could be stacking up evidence for a criminal case about themselves. This happened in both Bawa-Garba and Sellu to their detriment and goes against the principle of your rights being read out to you. Agreed facts go into trial but if you have admitted things when tired or upset then the court can call you a liar if you don't subsequently allow them to be heard. The Empey report was used against David Sellu in this way in my opinion.’

The Association of Surgeons in Training (ASiT) highlight the ‘...significant concern about the potential use of reflective practice notes in future criminal investigations among trainees. ASiT has previously outlined our concern that any potential use of junior doctors’ reflections in legal proceedings will negatively impact patient safety, duty of candour and surgical training.’
**Question 37. What is the charging standard applied by prosecuting authorities in cases of GNM/CH against medical practitioners? How does the charging standard weigh the competing public interest in improving patient safety?**

There were 341 responses to this question online.

This question yielded a lot of factual responses. For example, the BMA, along with a number of other respondents, responded simply that the standard is the CPS full code test. Many others set out the test for GNM laid out in the case law. 14 respondents said it is ‘unknown,’ 12 were ‘unsure’ and a further 17 said they ‘don’t know.’

A number of respondents indicated that they thought the (application of the) charging standard is unclear or variable.

The majority of medical professionals shared their views that the law of GNM is unclear/inappropriate/unjust in the medical context and the charging standard and decision to prosecute fails to take into account relevant factors, including the defendant’s state of mind (which they note the law does not require) and circumstantial (systemic factors).

In relation to the competing public interest in improving patient safety, there appeared to be a general consensus that the criminal charge is not intended to improve patient safety and so it is not taken into account. A number of respondents argue that fear of prosecution makes doctors practise more defensively and that this is not in the interests of patient safety.

**What is the charging standard?**

**England and Wales (GNM)**

Dr Oliver Quick (and other respondents) advise that ‘…Prosecutors apply the Full Code Test to such cases. This involves two aspects: the evidential test and the public interest test.’

Respondents add that ‘…the charging standard is applied by the Special Crimes and Counter Terrorism Unit of the Crown Prosecution Service. According to the CPS, the standard legal test applied is the four stage test from Lord Mackay set out in Adomako (1994).’ The evidential part of the test is that applying the standard tests in Adomako, ‘they believe on the basis of the evidence, they are more likely than not to get a conviction,’ another describes it as ‘...a reasonable chance of success.’ A few respondents also point to the ‘truly exceptionally bad so as to amount to a crime’ terminology/test, which they were more familiar with from the recent cases of Bawa Garba and Sellu.

**Scotland (CH)**

Law Society of Scotland noted that the Lord Advocate had published COPFS Prosecution Code outlining the test for criminal proceedings instituted in Scotland. These include:

- An evidential test
- A public interest test
The understanding of public interest test in GNM cases: Patient safety is not a function of the police and criminal courts

There was general consensus in opinion amongst many medical professional respondents that GNM convictions of doctors are unlikely to improve patient safety. Respondents repeatedly argue that GNM convictions do not have a deterrent effect or prevent the same harm happening again, saying for example:

’While one view would be that risk of prosecution and the publicity surrounding it should lead to reduced errors and greater safety. There is a good example disproving this. There have been a number of prosecutions following mistaken intra thecal administration of vincristine. Earlier prosecutions did not lead to prevention of the error. What has been most instrumental in preventing this is a change of protocol so that intravenous and intra thecal drugs are given at different times.’

A couple of medical professionals point out that the ‘...public interest seems to be ignored.’ And many others say that the public interest does not appear to take any consideration on the potential impact on patient safety. They recognise that the decision is based on whether the CPS can get a conviction ‘...rather than what is right for patients and patient safety.’ One respondent argues that the fact that ‘...the event could happen again e.g. a clinician has not learned lessons and is still a risk to patients, is in the public interest in improving patient safety’, however ‘...if an individual clinician is risk assessed as being low risk to causing this again then there is no future risk to patient safety. Otherwise it becomes a witch hunt where the relatives want someone’s head to roll and someone to blame.’

Interestingly Dr Quick shares his experience that ‘...in such cases [GNM in the medical context] it is highly unlikely for any public interest factors to point away from prosecution. This would be very unusual.’

He goes on to say ‘...It is difficult to measure how the public interest in improving patient safety is factored into such decision making. On the one hand, if care has been exceptionally bad and caused the death of a patient then it is difficult to claim that not investigating/prosecuting improves patient safety...whilst prosecutors will be aware of the claimed negative consequences of such prosecutions for creating a climate conducive to safer care, ultimately this is not their priority. They are making individual decisions in individual cases and wider issues of the best way of securing patient safety is not part of their remit or responsibility. They have to make independent decisions and are assessing whether there is evidence that GNM has been committed and whether a jury is more likely than not to convict. They are legally trained prosecutors not policy makers.’

Medical and Dental Defence Union of Scotland also advise that ‘there is a widely-held perception that pursuing GNM charges against medical practitioners in any, but the most exceptional cases are not in the public interest because it creates a culture of fear and defensive medicine; and is thus detrimental to the promotion of patient safety. To date, we have not observed that any particular weight is given to this wider consideration by prosecuting authorities. It is, of course, the case that when a clinician’s behaviour has been truly exceptionally bad then it may be in the public interest to prosecute but prosecutors
should always have in mind just how high a threshold this is and be explicit in their reasoning and justification when they believe that the case is made.’

A member of the legal profession advises that they ‘have no knowledge of how the CPS factor patient safety into a charging decision. In our view, patient safety should be a feature of the decision making process as it clearly serves the public interest for practitioners to learn from errors rather than being fearful of prosecution.’

Dr Jenny Vaughan believes that ‘…the public interest test is not well described or understood by many and needs looking at by the panel [ie this review]. The process needs a serious overhaul. Consider the example …of a GNM conviction which was deemed in the public interest in 2013 (R v Sellu) and then consider why all charges were found not proven at a civil standard in 2018 at the MPTS. This is why criminal GNM charges are so often way off the mark. No-one has been held to account over the process failings in this case. The only person to have paid is David Sellu who went to prison.’

A number of individual responses to this question certainly demonstrated the lack of clarity and varying understanding of the public interest test. One respondent claims, ‘…If there was wilful intent then to charge is in the public interest.’

Another respondent believes ‘…there is a serious conflict with the decision to prosecute an individual and the public interest in improving patient safety - since these processes have competing and conflicting objectives, and have run independently of each other. Public Interest is said to be the motivation behind both processes, and it is important to decide which is the overriding public interest.’

Another points out that they believe that the decision to prosecute is ‘subjective, as the standard is just a standard…the perception of "public interest" is likely to be a factor but, since this cannot be defined or measured, it's a useless (and quite possibly harmful) criterion. Certainly, "public interest" and "patient safety" are by no means equivalent, and it's extremely doubtful that one could genuinely influence the other.’

Others add that ‘public interest is not the same as public trial - grieving parents who are given prolonged periods of media time distort the possibility of fair assessment of a case.’

Recognising that patient safety is not the purpose of the criminal process, respondents comment that ‘...patient safety is for the trust to sort out internally which they can do by suspension (without attribution of blame but pending an investigation)...Improving patient safety comes naturally out of open and fair processes of investigating poor practice and not criminalising honest mistakes.’ Similarly another advises that ‘...the public interest in improving public safety is fatally undermined by having GNM/CH used to punish mistakes. If there was no malign intent or negligence, how would possible criminal sanction incentivise against making an unintended error?’

Faculty of Pharmaceutical Medicine argue that custodial sentences can lead to‘...suspension of registration. However, it is an open question if it should result in erasure from the medical register...public interest in improving patient safety should achieved through rigorous and open investigation of serious clinical events and deaths. The investigation should include the patient or their relatives. In addition removal of suspension from the
medical register should be accompanied by formal training and evaluation overseen by the GMC.’

Similarly another medical professional argues that ‘...even a seriously negligent medical practitioner should not be subject to criminal action except in the most extreme of circumstances. Serious negligence can and would be dealt with by the GMC and would often result in removal from the LRMP. Where harmful intent was not evident I struggle to see what benefit there is in criminal prosecution, especially weighed against the deleterious effect on safety culture when professionals are scared to report incidents for fear of prosecution. A dangerous doctor should not be a threat to public safety if they cannot practise any longer, or practise without supervision.’

**Variable or unclear charging standard**

The Royal College of Pathologists responded, rather curiously, that ‘it varies from case to case’, but did not elaborate on that comment. The Royal College of Surgeons also thought that it varies and suggest that ‘...guidance would help the CPS to decide whether to prosecute healthcare professionals accused of GNM and liaison with the Director of Public Prosecutions would verify whether this would be in the public interest in improving patient safety.’

Similarly, other respondents indicated that the charging standard/the decision to prosecute seems ‘to depend geographically’, ‘depends on the local plod’, or is ‘quite arbitrary and strangely disconnected from what fellow doctors would perceive as truly poor or negligent practice.’

One respondent claims that ‘...secrecy is the hallmark of British criminal proceedings. The decision on whether to prosecute or not is made behind closed doors, the case by case reasons to prosecute or not do not have to be made public, the preparations by defence and prosecutions take place beyond the public gaze, legal challenges are made behind the backs of juries and juries themselves retreat in private to come to verdicts which, under pain of prosecution themselves, they must never explain. Sometimes the faith we have in British justice strikes me as exaggerated, even if that confidence is as deeply and sincerely felt as the faith some tribes had in human sacrifice.’

An individual respondent (a retired doctor), wrote that there is no clear standard and that the Scottish system is ‘superior’ and involves ‘much clearer criteria’.

We are told by a medical professional that ‘...the standard is high but I have recently been involved in a GNM case (not of a medical practitioner) where the bar seemed low. This is in the context of a more punitive criminal justice system where sentences are longer and Judge's discretion is less. The need to show professional bodies are being tough concerns me as if appeasing certain groups and parties can influence decisions.’

Similarly another respondent argues ‘...The standard is farcically low. Historically we have seen tiny numbers of charges brought (until the last decade or so) but the clamour for blame has led to a more fervent and inappropriate use of the charge by police and CPS. Police and CPS should refer the matter to the GMC to deal with in all but the most exceptional cases.’
There were only a few responses from patients and family members to this question. A couple of them indicated that their view is seemingly the opposite of the respondent above (as well as a number of other medical professionals), saying for example ‘...the charging standard seems very high. Potentially this does mean cases might slip through the net with a resultant negative impact on patient safety.’ Another adds that they ‘...only know about prominent cases which are published in the press. Short jail sentences don’t seem enough in some cases so long as they are not let loose on humans again.’ Conversely, one patient or family member seems to take the opposing view, saying ‘...If doctors are being routinely arrested for deaths then no one will want to work as a doctor in the UK. Simple. Criminal undertakings should only be if intent to harm can be shown.’

One respondent held the belief that the ‘...charging standard applied is whether the doctor is “BME or not”. Dr Vaughan and other respondents also reiterated again here the issues identified in responses to the question about greater risk of investigation for particular groups of doctors (in particular BME doctors).

Royal College of Obstetricians and Gynaecologists say that ‘...the anxiety within the medical profession created by the Bawa-Garba case has emphasised that clinicians are uncertain about the charging standard applied by prosecuting authorities, and how and when a charge might be brought against them. Greater clarity and reassurance is required to support doctors to understand when and how the criminal law applies to medicine when a patient dies, including processes for initiating a prosecution. Clinicians need to be clear about the purpose and impact of all investigation processes and how and where GNM and CH fits in. Equally clinicians need to be provided with clear guidance on what is expected of them and of the organisations that they work for when a process has been started for a suspected GNM or CH charge.’

CH in Scotland – mens rea required and importance of public interest

The Faculty of Advocates noted of the Scottish context that as a result of the test for mens rea that applied in Scotland ‘it is inevitable that fatal clinical incidents will be dealt within the regulatory rather than the criminal system.’

Stuart Irvine, for NES, noted that CH is very different from GNM. ‘A genuine mistake should not be considered a criminal act’.

The Royal College of Psychiatrists Scotland also pointed to the need for ‘mens rea’ and ‘a degree of recklessness which could only be characterised as displaying gross indifference to the safety of the public.’ The College viewed the Scots approach as best practice, noting that ‘Public interest is vital in the respect of how it acts as a legal test’.

A couple of individual respondents echoed this view about the importance of the public interest test in Scotland, adding that the ‘...Procurator Fiscal generally does not consider it in the public interest to prosecute for CH.’

GNM in England and Wales and Northern Ireland- no requirement of mens rea

A number of respondents reiterate their views (as we saw in responses to the first section about what people perceive to be criminal acts) that there should be no conviction without
‘intent’. A few others say that ‘recklessness’ should be required with a few respondents claiming that ‘…the law in England should be equal to that in Scotland.’

**Nature of the offence and role of experts**

A respondent claims that ‘…this is completely unclear. The standard used by the courts is "truly, exceptionally bad", so it's likely that this will be the standard that the prosecuting authorities would hope to achieve, and this assessment in turn will be very strongly influenced by the (unvalidated) evidence of the expert witness.’

Another respondent questions the scope of ‘gross negligence’ and its meaning. They suggest that ‘gross negligence seems to imply a series of events where an intervention could be offered (mother with dementia being neglected by son for weeks or months). It is difficult to see how this can be applied to a few bad judgement calls in a relative short period.’

**The law and legal processes (admissibility of evidence) lead to ‘miscarriages of justice’ (GNM)**

Dr Jenny Vaughan ‘…Having spent the best part of 4 years overturning the Sellu conviction, my opinion is that most health practitioners don’t commit criminal acts when a patient dies. The criminal law is a very blunt tool when it comes to determining whether the death of a patient (especially in relation to honest errors of OMISSION rather than COMMISSION (but honest errors can be by commission too).

The recent convictions of Sellu and Bawa-Garba, are miscarriages of justice. This is because the contextual/system failures in both cases were not properly portrayed in court. Some key parties not charged either underplayed their role and their errors for fear of being held culpable, or they did not properly describe their roles or responsibilities. There is also a clear tendency for some key prosecution witnesses to plead “memory loss” for any questions which might mean they have to recall key details and the court just accepted that as an answer when plainly this was quite remarkable. These complex healthcare deaths should have been investigated by an organisation such as the HSIB and not put into the land of a criminal court. This is because QCs can exclude evidence and conduct character assassinations on dubious clinical events eg the DNAR decision in JA in R v Bawa-Garba where plainly this made no difference to the death of the victim.

Dr Vaughan recommends a few factors (which she calls red flags) for the CPS ‘…to take note of and think twice before prosecuting.’ These are:

- Comorbidities, multiple participants, complex pharmacology
- Systems failure
- Relying on the aggregation of medical errors for the charge
- Over-reliance on expert evidence
- Careful reliance on the source of information

Dr Vaughan summarises that ‘…the time is right to have very clear guidelines to avoid unsafe convictions.’

**The criminal process does not take account of system**
There were many other medical professionals who also held the view that system pressures/human factors are not adequately taken into account by the police and CPS. They say that the ‘...public are unaware of organisational factors such as lack of facilities for doctors especially juniors to have protected time to rest and have meals...’ The following quotes are demonstrative of the strength of feeling in this area:

‘The decision to prosecute an individual may be easier in law, but is profoundly unjust in a situation where complex system errors result in adverse outcomes and the accused is the unfortunate final step in a severely deficient process. Ignorance of and deliberate disregard of human factors issues by the judiciary are both shameful and profoundly unjust. It should be noted that judges hear one case at a time, and medical staff are often responsible for multiple patients, across multiple sites within the hospital, including unusual locations, and more than one patient may need urgent attention at the same time. To claim that they are trained for pressure so any degree of pressure is not valid as a mitigation is idiocy of the highest order.’

‘Most doctors go about their work with due diligence and are usually dedicated to the care of their patients...Patients are not dying just because of poor doctor behaviour, the significant majority have increased morbidity & mortality as the system is unable to cope with the current demands on it. Staffing shortages that lead to Locum slots being filled up by permanent locums whose quality of care is sometimes not up to a standard contributes to poor care and potentially to death. Weekend mortality is a good example of why staffing should be of similar intensity throughout the 365 days.’

**Realistic view of ‘in all the circumstances’ the doctor found themselves in**

As we have seen as a recurrent theme in responses to questions about the role of expert evidence, there are strong perceptions that the decision to charge seems to be based on the standard ‘...that the care fell below that which should be provided in ideal circumstances. Only rarely, if at all, does there seem to be any measuring against the yard stick of what would have been reasonable behaviour in those particular circumstances. [The doctor] has only brief contact with the patient on each occasion.’

A number of respondents also highlight their views that there is a lack of system accountability in GNM cases:

‘The hospital / CCG / surgery should take some primary responsibility for ensuring they have the right number and quality of staff.’

One respondent thought that ‘...where human factors play a part, corporate manslaughter is more appropriate than GNM, however the threshold for this appears to be even higher.’ However, as we have seen in previous responses, others do not necessarily agree that other forms of criminalisation are the answer – although noting that there have been repeated calls for the introduction of regulation of non-medical managers.

A few responses demonstrate the perception that individuals are ‘easier targets’ and that they are scapegoated or punished as a result of public desire to see punishment. Saying for example’...public preference is more important than true public interest. It is easier to see failures in terms of a person to be punished...individuals are easier targets than the
corporation under which the patient was cared for…decisions are made more on the probability of securing a conviction than on going after where the true fault lies.’

As we have seen as a recurrent theme in previous responses, the prevailing blame culture is highlighted repeatedly. Respondents advise that the punitive and learning agenda are not compatible and that the ‘blame culture and compensation cultures take precedence to learning.’

The Doctors’ Association UK believe that ‘…It is vitally important that patients are kept safe but patient safety is dependent on a culture of learning rather than apportioning blame. Learning from errors, sharing experiences and minimising system errors collectively make healthcare safer for patients. Having a low threshold for GNM, charging and convicting clinicians serves to undermine this just culture and consequently lead to fear and a reluctance to openly learn from errors.’

Based on public opinion, press or relatives

We were also repeatedly told that respondents think the charging decision might be ‘…influenced by pressure from the press, families and investigators (the latter highly qualified but subject to unconscious bias).’

There were many respondents who feel ‘family pressure has a large part to play.’ The following quotes demonstrate the strength of feeling in this regard:

- ‘heavily in favour of the louder the shout against a doctor the more likely to prosecute for “public interest”’
- ‘…driven by the emotional impact of the case and the anger of the relatives.’
- ‘…the charging standard is determined by public opinion not by the need to improve patient safety. Public opinion is largely determined by the media…the actions of the prosecuting authorities are largely determined by what they perceive the media will do and what they have reported to date. I have heard Colin Melville of the GMC state that "the GMC must pass the Daily Mail test". I felt that such a statement was totally unacceptable. The GMC and the courts should do what is right regardless of how the media may portray their actions.’
- ‘I don't believe the prosecuting authorities make any heed whatsoever to the public interest in improving overall safety. Frankly, they appear influenced by public opinion and behave like they have a quota (eg Operation Yewtree).’
- ‘GMC and CPS and police now seem to be more bothered by their standing in the red top press than anything-m like politicians.’
- ‘…there is often a strong lobby/political issue is decision to charge despite objective assessment by the CPS. Public interest in terms of safety (rather than press involvement etc) seems to be a minor factor.’
- ‘the CPS appears to be open to lobbying by the family and coroner. This itself can allow racial bias to play a role in decisions to prosecute. Note the number of BEM doctors prosecuted vs number working in the NHS.’

Specific vulnerability of doctors

We are told a few times (in various ways) that ‘…the doctor must be the only person after an incident is expected to write a confession. Every other citizen is entitled to a right of silence. The prosecution must prove the case. We [the medical profession] do not have this and with it must come protection from the law…criminal proceedings are often brought late in the process and the defendant may well have compromised a defence by earlier participation.’
Independent review of gross negligence manslaughter and culpable homicide

They say they ‘can see that it would be appropriate in these cases for there to be some sort of independent panel to review with the CPS, GMC and possible NHS England as well as other independent parties/organisations representing patients, the benefits and pitfalls in each case of proceeding with a prosecution and what the likely implication is on the public interest of each party’s role. This would strike me as a more robust process in anticipating unintended outcomes and balancing these competing objectives.’
Question 38. Are there factors which potentially hamper key decision makers in making fully informed decisions at each stage of the process, 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?

There were 351 responses to this question online.

As we saw in the responses to the previous question about the charging standard applied, a strong recurring theme here is that system/factors are not adequately understood and/or considered by lay people judging the case (police, CPS, Judge and jury).

Other key themes identified in responses (in terms of factors hampering decision makers), were issues with:

- Clarity and scope of the law of GNM (lacking mens rea requirement)
- the purpose of the criminal law in this context (punishment, but not an effective deterrent)
- reliability of expert witnesses
- the evidence presented in the case (including ‘biased’ serious incident reports)
- criminalisation of medical error preventing/not conducive to learning
- blaming/scapegoating of individuals and lack of system accountability
- peer pressure, public/media pressure, pressure from family members
- bias/discrimination
- length of police investigations and detrimental impact on all parties

Lack of clarity in the law

Some saw the problem for decision makers being the law itself. Royal College of Anaesthetists wrote that ‘more clarity is needed on a definition of GNM and when this applies to doctors.’

Criminalisation vs learning/patient safety agenda

Some believe that the criminal law wrongly concentrates ‘...on people rather than events - can someone be prosecuted, rather than what happened.’ Some said that the criminal route of investigation is so wrong for dealing with such incidents.

One respondent argues that ‘...there is a view in the literature that investigatory and prosecutorial resources are skewed towards the investigation of gross negligence manslaughter cases to the detriment of other cases e.g. rape. All that police time and money wasted when violent crime rates rise and the risk of terrorism is high. Rather than prosecuting people who are trying to help society resources should focus on the criminally minded who do criminal acts maliciously and intentionally. How does society benefit by prosecuting, incriminating and imprisoning hard working professionals who as humans will make honest errors?’ However, they do not provide references for the literature they point to.

The 'public interest' in prosecuting negligent doctors where there is no deliberate maleficence or harmful intent should be considered to weigh very light against the importance of a pro-reporting, sensitive, human factors-based approach to investigating and understanding incidents. The latter has such broad implications for the culture of healthcare and ultimately the success or failure of incident investigation and risk mitigation that it should be clearly understood that prosecution is a very narrow interest indeed and
does not provide a great deal by way of improvement in (or maintenance of) patient safety.’

**Difficulty in gathering reliable evidence and risk of concealment of evidence**

A few respondents particularly indicated they believe that a factor hampering decision makers is the difficulties in gathering ‘all the relevant evidence... much of which will be “soft evidence.””

A member of the legal profession says that a factor that can hamper key decisions is that ‘...they may not have adequate information or evidence relating to context because appropriate questions have not been put to witnesses. In addition, the individual subject to the investigation may have relied upon a pre-prepared statement and/or elected not to answer further questions, therefore providing contextual information for the Police to rely upon.’

Medical and Dental Defence Union of Scotland advise that ‘...Often organisations and witnesses are either not asked for, or are reluctant to share with the police, information regarding the context of any error by a clinician such as staffing, length of shifts, resourcing difficulties, interpersonal/departmental issues, previous incidents etc. In some cases, this information has been provided to the police and/or prosecution experts extremely late in the day and has led to prosecutions collapsing at the doors of court.’

A number of respondents indicated that there is ‘...a culture of self-protection within trusts, and a large potential for presenting the facts in a way which creates a scape goat...the prosecutors/police rely on what the representatives of the vulnerable trust and upset relatives are telling them.’

One respondent highlights that ‘...trusts are also an accusee but investigate the other. A bit like one burglar investigating another for a crime they committed together.’ Another has ‘...no doubt that a potentially-culpable organisation will likely do everything in its power to transfer sole blame to a disposable individual. There are parallels with the treatment of whistle-blowers here.’

Another believes that ‘...the more senior doctors are adept at not accepting responsibility for their junior staff.’

**System factors and unique pressures of medicine are not given much weight or not understood/recognised**

The overwhelming majority of responses from the medical profession highlighted that system factors and unique pressures of medicine are not given much weight or not understood/recognised by the police or CPS. An anonymised diary entry, (documented in the first three months of being investigated for GNM, before the case was closed with no further action) provided by a doctor’s defence organisation demonstrates their feelings in this regard. They write ‘...Got home feeling absolutely terrified because I was beginning to realise I was in for a very lengthy process where the police/CPS do not have a common sense understanding of medicine.’
Many respondents reiterated that individual practitioners ‘rarely work in isolation’ or with truly bad intentions. They also reiterate that doctors are humans and prone to mistakes. ‘Non-medical people (eg police) have to try to understand the complexities of the situation...They do not specialise in this, and may lack consistent advice.’ Another respondent felt that the ‘key decision makers often do not care about the system pressures.’ However other evidence suggests that they do try to consider it, for example MDDUS say ‘...Whilst acknowledging that in most cases, lay police officers tasked with investigating medical manslaughter make considerable efforts to understand the medicine involved, in the early stages of an investigation they are inevitably very dependent on the information provided to them by the organisation/witnesses involved.’

A number of respondents referred to specific pressures in the responses, the following are some of those identified:

- System pressures - number of patients waiting to be seen, time taken for patient to come to hospital, nurses not doing observations
- Individual pressures e.g. medical consultants forced to work 24 hours in hospital due to sickness
- Unrealistic demands from senior management team e.g. for a consultant review every day over the weekend for all medical patients.
- time pressure,
- IT problems,
- patient related issues,
- underlying clinician health.

NHS Improvement ‘...are concerned that when the police are investigating incidents, they may not always have access to people with a deep understanding of the realities of the type of healthcare relevant to that incident. They may also not have sufficient access to individuals who are expert in the influence of systems, environment, culture and other human factors related aspects on the performance of people in work. We believe that should the police have early access to this kind of expertise then there would be very few instances where the police would recommend prosecution of individuals and this would be much more likely to only happen where the actions of individuals are likely to have been ‘criminal’.’

Association of Surgeons of GB&NI felt that political expediency too often got in the way of proper account being taken of circumstances: ‘individual clinicians have frequently been “sacrificed” in order to avoid potentially politically uncomfortable revelations concerning resource short falls, lack of workforce planning, lack of training, lack of supervision of juniors etc.’ They refer to Ian Kennedy’s RCS presentation. Stuart Irvine (NES) took a similar view, saying that the big problem was the desire to find someone to blame.

BMA identified a number of factors hampering decision makers:

- Lack of resources allocated to investigations at a local level
- Medical experts have to be instructed early and there is a need for early liaison with the CPS Special Crime Division
- Prosecutors should have human factors training
• Experts need to understand their duty to be impartial and to understand GNM.

DAUK felt that what hampered decision makers was that ‘too often system pressures and human factors are downplayed in investigations’ while investigators have ‘little or no training’ and at local level ‘are often under resourced’.

Similar themes are seen in other responses. MSC wrote of a ‘lack of an all cause analysis and lack of awareness of system pressures’. The Royal College of Psychiatrists argued that ‘Decision makers must understand that healthcare is an organisational and multifaceted system...’ The Royal College of Radiologists referred to the ‘potential risk...that they examine the case in isolation rather than in full context of the systemic, organisational or national factors...’

An individual respondent noted that context is crucial in judging the actions of a doctor. In order to address this need for contextual understanding, MDDUS argued that it was vital for the police to meet senior clinical managers early in the process to ‘establish any relevant contextual issues, systemic failings...’

A Family member agrees that ‘...Yes - it is impossible to take out of the way the multiple factors that doctors, nurses, heath care professionals etc think about all at the same time. There are so many pressures on the NHS that people can only be treated the best way possible based on all those factors. Obviously the patient's best interests must be at heart but there are loads of other things to be taken into account like if there is only one bed available and two patients to decide from about who gets the bed, then the patient who would benefit most may get the bed. But that doesn't mean that it's ok to blame doctors, nurses etc if the other patient is adversely affected by not getting a bed (even if the ideal scenario was for both patients to have that bed) because priorities and risk/benefit balances have to be made all the time and if HCPs had the pressure of a possible prosecution or disciplinary action over their head then everyone would act very defensively. This would massively overburden the NHS and costs would spiral.’

‘Hindsight is a wonderful thing. You need to try and put yourself in the position of that individual at the time the error happened’

Respondents argue repeatedly that ‘...things are always blindingly obvious with the retrospectoscope,’ or put more simply, hindsight. They add that ‘...ideally an investigator would be looking at all the cases being dealt with at the time of the incident. They should have a bleep going off every 5 minutes and a few emergency calls to the A&E department and no prior knowledge of which case it was that had the bad outcome.’

A couple of respondents suggest that there should be some form of a re-enactment or simulation of the situation the accused doctor found themselves in at the time the alleged GNM occurred ‘...such as in aircraft investigation programmes’. They argue that this would result in a more adequate assessment of all the circumstances.

Dr Oliver Quick provides pragmatic advice that ‘...Evidence will take time to collect, and key decision makers will be waiting for experts to compile reports and for those experts to stick to their terms of reference. As with all such investigations, decision makers are reliant on the willingness of others to offer full and honest statements. As I understand it, as such
cases are invariably complex, there is often considerable communication between police and prosecutors over gathering evidence and seeking further detail and clarification where necessary...There is no reason in principle why such decision makers should lack a fully informed picture before making decisions, and indeed, obtaining such a fully informed picture is likely to be one of the main reasons why such cases often take so much time between date of incident and date of decision. But of course this is reliant on that fuller picture emerging through various pieces of evidence, not just the statement of the suspect, but from others associated with the delivery of care in a particular unit on that particular day in question. It is hard to know whether such evidence is always made available.’

Unlike the majority of respondents, there were few respondents who cautioned over-reliance or inappropriate reliance/consideration of circumstantial factors for example an Australian lawyer argues that ‘...System pressures should only be taken into account after establishing the facts - they may be factors that can mitigate and alter the action subsequently taken but they should not alter the facts - is the treatment of a patient in one setting going to be acceptable when it is not in another - there must be equity in the provision of health care across the system.’

One family member shares their experience of a local investigation saying that a factor that hampers decision makers is ‘...Time they take to investigate cases. I had to wait until they had all had their summer holidays!’ They go on to say that ‘...the Trust complaints procedure is ridiculous. “Systems pressures” I was told after. They always blame system pressures for their decisions. IT errors how can you lose 10 x-rays! A CQC inspection! Going on at the same time Jr doctor left in charge in an ICU ward able to make life or death decisions!’

Another family member shares the following comment in response to this question ‘...Unity against manslaughter at the current time, as the system is FAKE! Simple neglect, they all should be charged!’

**Importance of a ‘proper’ local investigation being carried out before other investigations**

One respondent shares their experience of being investigated by the police, the GMC and then their employer for GNM 9 years ago. They believe that ‘...If a proper local investigation were to be carried out taking into account system pressure, error or failures then much hardship could be avoided. But because of the immediate closure of access and communication caused by a ‘death’ none of this happens until after the legal process has been completed. A good example is; working as the Intensive Care consultant covering both the Cardiac/general unit (10 beds) plus the new adjacent general unit (6 beds) is a situation against Intensive Care Society guidelines which recommends no more than 8 beds per consultant. Plus individual consultants work different days preventing continuity of care. Several times proposals are written and presented to the Chair who refuses to implement a plan to have same consultant cover for several days and recruit more consultants. Such a system would have completely avoided an ensuing manslaughter case. Having refused this proposal, when it was recommended by a local investigation after the manslaughter investigation it was implemented immediately. However the accused doctor has been
punished by the suffering which could have been avoided. An unbiased local investigation would see this immediately. It would mitigate for the doctor accused and enable early implementation of a better system...In fact the opposite happens. The police enquiry focuses only on the death and not on any service related issues and certainly not on reflective concerns that may otherwise be considered learning opportunities.’

**Lay jury**

Many respondents believe that ‘Lay juries are not best placed to have a thorough understanding of how it is working under these system pressures.’ One respondent adds that it ‘...is very hard to explain how it is to be in a pressured environment to a jury and that a jury of one’s peers who do know that would often have a different standard.’ This respondent goes on to argue ‘...that if the standard used by the jury in cases such as *Sellu or Bawa-Garba* were applied across all medical decisions a great many doctors would be convicted because they hold individuals accountable for every day factors beyond their control.’

A respondent argues that ‘...In an antagonistic courtroom situation the possibility of properly explaining [the complexities of medical cases] will be even more limited. Worse, by that point the patient or relatives (and possibly the public) will have been led to believe that a crime has been committed, even if this is far from fair.’ Another adds ‘...It is legitimately difficult, even for doctors, to know where to draw the line between doing the best possible in an impossible situation and being a poor doctor.’

**Independent and experienced medical expert input crucial**

There was a lot of recognition that even within the medical profession there would be a limited number of individuals that would truly understand the full context/would be accustomed to working in the particular environment an accused doctor was working in (including doctors from other specialities/ hospitals: the culture and work load of each is subtly different), saying that because of this they could seriously underestimate the system pressures. They advise this is particularly the case in specialties/areas of practise where the focus is on an individual’s culpability relating to a single patient/incident when they are required to see ‘a huge number of patients under serious time pressure.’

They say for example ‘...In Critical Care medicine, understanding of the decision making and time pressure is extremely hard, especially by a non-critical care practitioner. Decisions often have to be made in seconds.’ And ‘...outside of a relatively small proportion of people, even within the healthcare professions, a full understanding of the complexity and pressure of working as a doctor is hard to find. That is not to say that careless or reckless acts should be excused on the basis that we work in difficult circumstances, but independent and experienced medical experts are absolutely crucial in assessing and weighing evidence in complex multifactorial clinical scenarios. Specialist medicolegal expertise, in touch with current clinical medicine, is essential in guiding charging decisions and should weigh very heavily.

**Problems with expert witnesses**
As we have seen in many responses to previous questions, a recurrent theme repeated here is that caution must be had with regards to the reliability of expert witness evidence. They say for example that the factors that hamper decision makers, include ‘...the vested interests of expert witnesses or their background and their ability to truly be objective about the exact circumstances, for example a consultant of 20 years will not be totally familiar with how it is to be a registrar on a registrar rota.’

Respondents also argue that ‘...Expert witnesses may be called upon, but may not be consistent. They may have extreme views. Or they may simply lack the necessary perspective (can a consultant aged 60 truly understand the pace of a current junior doctor’s workload? Some of my senior colleagues' views on EWTD would suggest not!’

Another respondent cautions that ‘...doctors [including experts] are not immune to bias and may judge colleagues they dislike more harshly - this also has scope for unconscious racism.’

**Length of police investigations and lack of expertise a potential cause of delay**

A number of respondents argue that the ‘...process [is] too lengthy’ and some respondents say that the lack of expertise/understanding within the police is a cause of delay.

One respondent says that their ‘...friend has recently been investigated by the police for GBH. The charges have been thrown out by the CPS as they couldn’t find any evidence of wrongdoing. There was no hospital investigation before the incident was reported to the police and the hospital wouldn’t start investigating until the police investigation ended. My friend’s experience was that the police didn’t understand any of the clinical circumstances at all and they couldn’t understand the evidence in front of them. The police investigation took 18 months and the hospital has not yet started their investigation. The incident was two years ago. My friend has been of work all this time with stress and depression as a result of the way the investigation has been handled. He doesn’t understand what it is he is supposed to have done wrong (he thinks he is accused of withholding analgesia, but he prescribed a PCA). Unfortunately, he is too traumatised to be able to answer this questionnaire himself.’

**Lack of system accountability**

As we have seen in many previous responses, a recurrent theme was that medical professionals do not believe that the system/employing healthcare organisation is held to account in GNM cases.

‘...people do not ask questions they do not want the answers to. In the example of the Bawa Garba case, regardless of her culpability, what would have happened if the NHS or the CEO of leicester had been found guilty instead...! The system itself is guilty for much of the harm that befalls out patients.’

Whilst a number of respondents call for greater system accountability or for more corporate manslaughter charges, one respondent highlights caution that ‘...more legal opportunities to prosecute will only worsen the situation. A clear common sense approach is required before the train of legal professionals get involved. Increasing corporate manslaughter will only increase the total legal machinery and not reduce prosecutions at an individual level.'
Having worked in Scandinavia, New Zealand, USA and the Middle East, I now think that the UK has become one of, if not the worst for out-of-control legal involvement.’

**Media portrayal**

We were also repeatedly told that ‘media hype and public reaction’ is a factor that hampers decision makers. They say that ‘...the media will often judge the doctor before the end of the process - guilty until proven innocent.’

We can see in the aforementioned doctor’s diary entry (documented in the first three months of being investigated for GNM, before the case was closed with no further action) that fear of the media was prevalent for them and impacted on their health and wellbeing. They say ‘...I am terrified of the prospect of something could go wrong and could not possibly put myself in a position where this could happen again...I also do not want the possibility of the investigation to leak into the press and become known to a patient that I have to treat... I am thus unable to return to my previous post; the NHS has lost another experienced hospital consultant from the frontline.’

A number of respondents also highlighted the 'bias and racism' they have seen from ‘reviewing the social media comments on the Bawa-Garba case. This also demonstrates huge vocal racial bias.’

**Pressure from families to prosecute**

The family always want blood. They can say and do anything in public or private with impunity. Their influence is, wrongly, enormous.

**Peer pressure**

One dissenting voice came from a medical professional who suspects ‘...that there is a certain amount of peer pressure. As an example, I felt very uncomfortable expressing doubts about Dr Bawa-Garba's innocence and pressure from colleagues to conform to the view that she had been made a scapegoat.’
**Question 39.** Do the key decision makers (the police senior investigating officers (SIOs), and/or prosecuting authorities) have the necessary support to enable them to make fully informed decisions on whether or not to charge a doctor of GNM/CH? Is there a need for detailed prosecutorial guidance for this offence (similar to that for assisted suicide)?

There were 355 responses to this question online.

Most of those who commented on this question felt that the decision makers lack both the necessary expertise and support. There were mixed views about the prospect of detailed prosecutorial guidance (the majority were in support vs fewer respondents who didn’t think it would improve the situation for a variety of reasons).

12 respondents said they were ‘unsure’ (with a few saying that they suspect police don’t have the necessary support). Nine respondents said ‘no idea,’ a further nine said ‘unknown.’

**Necessary support to make fully informed decisions?**

As we saw in responses to previous questions, most respondents acknowledged that these cases are rare which means that police were unlikely to have specific experience and strongly held the view that the police ‘...do not fully appreciate the role of medical staff, the clinical issues, and the other circumstantial factors.’ Many respondents also said that they do not believe the police have the necessary support to make informed decisions (this included a patient or family member, many medical professionals and the BMA and both the Royal College of Surgeons Edinburgh and England and other bodies).

The Royal College of Surgeons England (RCS England) say ‘...they have sometimes encountered difficulties when advising the hospital commissioning the review to refer cases of suspected GNM to the police. Often the police do not have any experience of handling the multiple and complex factors surrounding a death in a healthcare setting.’

The British Society of Gastroenterology also say that in their experience ‘...legal decision makers very rarely have the necessary support to enable them to make an informed decision. Evidence for the Coroner and Procurator is usually gathered by Police Officers. Giving a statement is often a very laborious process and has to be spelt out (literally) and explained. Often one is left with a statement that approximates to what has been said but may not capture the nuances and is almost certainly written without any clear understanding. Yet these statements often form the basis on which a decision to hold an FAI or prosecute are made.’

There were a few respondents who felt that the lack of support and guidance for police is ‘obvious’ based on their ‘past decisions.’ One medical professional claims that ‘...experience is limited in this area and this shows in the poor and inconsistent decisions of CPS, and the number of cases thrown out by the court.’ Another adds ‘...Decisions seem capricious, and tend to refer to court rather than decide a more appropriate route.’ Again another medical professional says ‘...There have been some terrible decisions. That poor anaesthetist who’s case was thrown out on the first day of the hearing when he tried to save the post-natal lady who never recovered after post-partum haemorrhage & GA. Mr Sellu, Dr Bawa garba - both miscarriages of justice.’
One respondent believes that ‘...the prosecuting authorities, whilst wishing for justice, are largely more interested in their own career advancement than actually finding the truth. Sadly, whilst being well qualified in law, they are usually completely uniformed and unable to make judgements on medical matters.’

**SIO guidance**

MDU pointed out that the latest SIO guidance ‘does not refer to how expert reports should be constructed’ and that there was no reference to the criminal procedure rules. It regarded the guidance as deficient.

The BMA went on ‘...Existing Senior Investigating Office guidance about this type of investigation is out of date and limited in some areas.’

MDDUS shared this view: ‘insufficient support for decision makers in England and Wales because the guidance as it stands is inadequate. It referred specifically to the Senior Investigating Officer’s Guide to Investigating Unexpected Death and Serious Harm in Healthcare Settings and the CPS Guidance Homicide: Murder and Manslaughter which it described as ‘brief and less than helpful’ in some areas.

It sums up: ‘MDDUS considers that clear, detailed guidance is required to address the legal test for GNM and it should include specific guidance on medical manslaughter.’ MDDUS add ‘the guidance should be clear as to the importance of unambiguous expert evidence from an expert who, not only has the necessary clinical and service management knowledge and experience, but who also has been fully versed in the relevant legal test and is aware of the standard required to secure a criminal conviction.’

**Calls for the development of detailed prosecutorial guidance**

Most respondents said they thought there is a need for detailed prosecutorial guidance (including for example the BMA and RCS Eng) or that it would be ‘helpful’.

Dr Jenny Vaughan also believes there ‘...needs to be standardised guidance for who is referred to CPS... It would seem only reasonable that there should be specific advice relevant to healthcare professionals.’

One respondent advises that because the police ‘...are strongly guided by expert opinion and by focusing on the individual case/patient rather than whole systems. Guidance on how to take this into account would be valuable for police and prosecutors.’

An individual medical professional sees ‘...a need for detailed guidance, focusing heavily on the question of criminal intent or extreme, criminal recklessness being required for prosecution, and promoting grave consideration of the disadvantages for safety culture and thus wider society when decisions are made to prosecute for GNM.’ This was a relatively commonly held view (ie that the guidance should caution against criminalisation of medical error in the absence of recklessness).

Another adds there is a need for ‘...investigation guidance of best practice, involving ideally a collaborative approach, whilst maintaining the integrity of the criminal justice system’s independence, which is a definite overriding public interest.’
DAUK followed a similar theme: ‘There is a need for clear detailed prosecutorial guidance.’ And ‘Guidance for CPS on how to identify cases of true GNM, distinguish them from cases of system error and corporate manslaughter.

The Royal College of Pathologists felt that prosecutorial guidance would be ‘extremely useful’. So too did the Royal College of Radiologists.

The Association of Surgeons in Training (ASiT) say ‘...there is a need to obtain a clear statement on the law of gross negligence manslaughter and a definition of the threshold of GNM within healthcare, which is thereafter implemented consistently in the Crown Prosecution Service (CPS).’

The Royal College of Anaesthetists referred to the need for ‘greater clarification of what constitutes GNM/CH in healthcare so that prosecutions...follow a consistent and equitable process across the UK.’ Royal College of Physicians and Surgeons Glasgow was another college which referred to the need for ‘clear definitions’.

One respondent cautions that whilst ‘...detailed guidance would be very helpful’ this can only be done ‘...when there is a consensus on what the threshold for the offence should be. Some suggested that there should be a public debate about what that guidance should say.’

Another points out that there was a Williams Review recommendation t that a working party between the Crown Prosecution Service (CPS), Chief Coroner and medical defence societies agree on the definition of ‘truly, exceptionally bad.

The Royal College of Paediatrics and Child Health called for medical expert advice to the CPS to help prosecuting authorities ‘understand the facts’. Stewart Irvine (NES) also felt that ‘In general, they do not have the skills and experience to make a judgement on complex medical evidence’.

The Association of Anaesthetists GBI (AAGBI) say ‘...In addition, Senior Investigating Officers should have access to a national resource to assist them in assessing evidence and applying the tests described in the charging guidance.’

**No, guidance ‘won’t help’**

A few respondents did not believe prosecutorial guidance would be appropriate. They say:

‘The law is so flawed that even detailed prosecutorial guidance is unlikely to help. More complicated guidance would not aid the extremely limited understanding of investigating police officers and would not, for instance, help a lay jury to reach an informed assessment of the many technically complex areas they are obliged to assess. This would be no more than window dressing; a change in the law is required.’

‘The assisted suicide guidance is hardly a good model - it is fraught with uncertainty.’

‘Detailed guidance merely clouds an already complex issue that requires common sense.’

‘Do they abide by the guidance if there is one is the question.’ This retired doctor says they ‘...are reassured that Dr Bawa-Garba's reflections were not used in the courts against her. But the prosecutor would have seen this in the notes of the patient and realised that he can...
strengthen his case further by making her own consultant a crown witness. This is one of the reasons why the case against Dr Bawa-Garba stinks putrid.’

Dr Oliver Quick shared his ‘...impression is that the CPS does have the necessary support to make fully informed charging decisions. Cases are handled by leading prosecutors working in a unit with considerable expertise and experience. The question about the need for detailed prosecutorial guidance is interesting. On the face of it, the definition of GNM is so vague that detailed guidance may seem like a good idea. However, in reality I wonder how such guidance would really differ that much from the existing factors listed in the Code for Crown Prosecutors -i.e. the Full Code Test.

Whilst such guidance might aid more consistent decision making, it could also lead to a mechanistic application of certain factors for and against and end up diluting prosecutorial discretion. Obviously it is hard to say with any degree of certainty whether that is desirable in every case. In terms of transparency and accountability of decision making, there does appear to be an arguable case for such guidance. But this clearly requires careful thought and some preliminary research. I am about to start such a research project (which I have already made the review team aware of) and will hopefully be able to feed in the findings to the review at a later date.’

A legal professional (QC) says that ‘...The guidance in the Assisted Suicide cases is concerned with the very difficult task of making the decision as to whether there should be a prosecution for such an offence where there is sufficient evidence to do so; the public interest test. I have not come across a case of GNM where a decision has been made not to prosecute a case where the there is sufficient evidence to do so, on public interest grounds. Is it suggested that there may be cases [other than the wholly exceptional which can never be defined in advance] in which it would not be in the public interest to prosecute a medical professional who has caused the death of a patient by his/her gross negligence?’ This reflects Dr Quick’s experience that it would be highly unlikely for the CPS not to prosecute on public interest grounds in GNM cases in the medical setting.

Scotland

Law Society of Scotland was rare among respondents in saying that decision makers are competent and didn’t require additional support: ‘In COPFS these cases are dealt with by specialists and therefore sufficient expertise exists to undertake appropriate investigations.’ They add: ‘There are no specific detailed prosecutorial guidelines in Scotland. Such cases are unusual and therefore very detailed guidance is unlikely to be helpful given the breadth of scenarios that may arise...’

**Early engagement with the CPS Special Crime Division in all GNM cases involving healthcare staff**

The BMA ass that ‘...It is crucial that there is engagement with the CPS Special Crime Division in all GNM cases involving healthcare staff.’

**Greater involvement of medically experienced individuals**
NHS Improvement believes that ‘...access to a range of expert advice seems much more important than a written guide.’

An individual medical professional similarly calls for ‘...unbiased third party advisors’ who might ‘...help reduce misinformed decisions and miscarriages of justice.’

BIDA argued it is ‘important to introduce a formal role...of expert medical advisors familiar with the working of the NHS to ensure that matters relating to an individual practitioner as well as corporate responsibilities are fully understood and interpreted...’ It further advocated ‘a programme of “specialist training” for the officers of both agencies in order to increase competency and sensitivity.’

Dr Vaughan also says ‘...I would also expect that a group of senior clinicians were involved in any decision to prosecute and were satisfied of the negligence...there probably needs to be pre-vetted experts (or a dedicated response team) which can review the case and advise after this point.’

One respondent thought that ‘...An independent review panel should be the initial first step unless there are grave overriding extraneous circumstances.’ However they didn’t say what the review panel should look like, (i.e. medical, non-medical, which organisations).

As we have seen as a recurrent theme in previous responses the British Society of Gastroenterology say ‘...the assessment of complex medical cases needs reliable unbiased professional advice. At present the pool of advisors is limited, unregulated, and not subject to any form of appraisal or assessment.’

**Dedicated unit/third party advisors**

MPS described meetings with ‘various police bodies’ where there has been ‘ready recognition on their part that individual forces...do not possess the requisite experience and expertise of “medical manslaughter” to achieve a consistent specialist investigation. We believe there would be a broad consensus around centralising these investigations in a single body’.

MPS goes on to express satisfaction that the Williams Review accepted the need for police forces to ‘consolidate their expertise’ through the creation of a virtual specialist unit. MPS wants ‘national guidelines...created for investigating healthcare professionals suspected of GNM, and all such investigations should be carried out by a lead police force.’ It sees the Williams Review recommendations as going a long way to achieve that.

DAUK and RCS England also say they also recommend that a national specialist unit should be established within the police force that has the expertise and experience to handle GNM cases.

One respondent advised that ‘...A special section of the CPS should be set up just to deal with this [the virtual unit of experts].’

A member of the legal professional agreed with the calls for detailed prosecutorial guidance and said that it ‘...should be shared with any expert instructed by the prosecution to assist in their assessment of the grossness of any breach.’
**Issue is probably access to support**

One respondent shares their view that ‘...the police and CPS seem to be very inconsistent...If such support exists, it's certain that the police, and probably also the CPS, have no idea how to access it.’

**Call for approval of decisions to prosecute from DPP**

One respondent thought that ‘...decisions from senior CPS person experienced in this area is also important.’

MPS further argues that there should be a requirement on the Director of Public Prosecutions to personally authorise all prosecutions involving a healthcare professional accused of GNM and that the DPP should be under a requirement to issue a public statement on why the public interest is served by prosecution.

Similarly, the Hospital Consultants and Specialists Association (HCSA) ‘...believes that in the sensitive and complex clinical setting, the decision-maker should be the Attorney General. A change to the law to set a clear legal bar would assist in this, as would the establishment of a specialised team whose investigation would inform the Attorney General’s decision.’

**Training would be better**

Seven respondents say that SIOs should have training in these cases. One of those respondents says ‘...they have support, but I would suspect this is not without pressure, the patient will always be the victim so difficult to be seen to be against their opinion. Training rather than guidance would be better.’

**Call for GMC guidance for doctors in managing high risk situations**

One medical professional thought there should also be GMC guidance ‘...for clinicians in identifying high risk situations and understanding how to manage these...where there are more than one patient requiring intervention/attention and the system is unable to provide this due to being overwhelmed. This provides an ethical conflict when working clinically, but also a legal problem when having to assess if mistakes were so bad as to be criminal, as when the errors are taken out of the whole context it is difficult to understand how those decisions were made, but once put into context often easier to see how the error could be made.’

**Learn not blame**

As we have seen as a recurrent theme in previous responses, there were respondents who said that criminalisation of individuals does not result in learning and improvement of patient safety. A Reference was made to ‘...the Nottingham case of the wrong chemo preparation being injected via LP. The issue was resolved by altering syringe LPneedle provision rather than castigating the individual who was involved in the 'error waiting to happen.”

**Unique vulnerability of the medical profession to GNM charges**
ASiT say that whilst it ‘...acknowledges the number of cases of GNM remains very small, there is clearly a disproportionate number of healthcare professionals referred to the CPS for GNM, as compared to the normal working population. Approximately 200 cases per year are referred to the CPS. From 2013-2018, 151 were medical cases i.e. 15%, which is three times higher than the proportion of the general public.’
Question 40. Why do some tragic fatalities end in criminal prosecutions whilst others do not?

There were 402 responses to this question online.

Among those who responded to this question, the clear consensus was that there is inconsistency in the decisions to prosecute medical GNM cases and it was most commonly reported to be (at least partly due to) pressure from families, the public and the media which brought certain cases into the criminal arena. The word ‘family’ was used 95 times in online responses, ‘families’ 36 times, ‘relatives’ 23 times, ‘public’ 36 times, ‘press’ 15 times and ‘pressure’ 45 times. Political influence was also repeatedly mentioned (‘political’ was mentioned 16 times).

Added to this, the lack of guidance and expertise available to decision makers meant some inconsistency about what is taken forward and what is not.

Dr Oliver Quick, summarises the following as key factors which are fairly representative of those identified by other respondents in general:

- Character of victims (age and vulnerability)
- Active family
- Publicity
- Coronial assessment/referral and coronial prevention of future death reports (Regulation 28 reports)
- Interviews of suspects and preliminary impressions about conduct and character
- Liaison between the police and CPS
- Expert witness reports
- Character of defendants
- Ultimately, the decision of prosecutors in the CPS Special Crime Unit.

The role of the coroner and their guidance

BMA argued that ‘the role of the coroner is crucial here’. And that ‘Guidance to coroners to ensure they only refer cases to the police where it is appropriate to do so is needed.’

A member of the legal profession advises that ‘...much depends on when and how decisions are made to refer for criminal investigation. Medical Directors and Coroners, for example, will have different personal thresholds for referral.’

The Royal College of Obstetrics and Gynaecology argue that ‘...Little evidence exists to demonstrate how a charge of gross negligence manslaughter and culpable homicide is bought or the circumstances in which a referral for these charges is to be made (coronial referral, CPS route, police route, trust reporting routes). The lack of clear guidance on the criteria that must be met for a case to be escalated and investigated as a charge of gross negligence manslaughter is something that needs to be addressed urgently.’
Royal College of Surgeons Edinburgh also believe that the ‘processes are vulnerable to individual bias or competence.’

One family member shares their opinion that ‘...the coroner is the significant deciding factor in this decision our child was killed in a nearly identical way to another child across the country. The coroner dealing with our sons case did not refer the matter to the police, the coroner dealing with the nearly identical case in surrey did refer the matter to the police. Clear and detailed guidelines on clinical standards and what is considered to fall so far below these guidelines it is considered criminal should be issued for all coroners and the CPS to consult when deciding if an action is criminally negligent. This should be done to provide clarity and equality to both them and to doctors and could in fact help doctors to stay on the right side of those guidelines. There must be clear guidelines for police involvement. The current neglect test is insufficient our sons inquest returned a verdict of gross negligence yet there was no police involvement. Our child died because two hospital staff ignored a hospital policy in place to protect its patients. In our opinion this should be considered criminal, hospital policy is there to protect patients, if doctors can now ignore it at will without consequence what good is the policy doing? How can the trust protect its patients, if it cannot rely on its staff to follow safety policies?’

Respondents generally argue that some end in charges, whilst others don’t because ‘...there is no standardised guidance.’

The Royal College of Anaesthetists referred to the ‘lack of clear guidance on what constitutes GNM and CH in healthcare and the absence of a single overseeing constabulary leads to an inconsistent approach being applied...often leading to different outcomes for similar investigations. This is compounded by a lack of expertise in assessing these rare cases by individual local offices of the CPS.’

**Pressure from family members**

The Royal College of Pathologists (RCPat) was typical of many of the responses to this question: ‘These decisions appear to be random and may be related to pressure groups and the desire of relatives for retribution.’

One patient or family member comments ‘...It is only by the actions of groups and individuals who have the strength to persist.’

MDU echoed the RCPat’s views about the ‘lack of consistency in decisions to prosecute or not’ and said that the chances of a ‘criminal investigation are increased where there is pressure from the family of the deceased, and/or where the case involves the sudden and unexpected death of a child...’ Also, where there has been an exhaustive investigation in response to family pressure the totality of evidence may reach a ‘tipping point’ where it is thought appropriate to let the jury decide. MDU further suggests that the police report may be coloured by the fact that individuals have invested a lot of effort in their investigation and want to see a tangible outcome.

MSC also picked up the theme of ‘family pressure’ as a possible driver behind criminal prosecutions, but acknowledged that ‘it is likely there are a number of reasons’. The Royal College of Physicians and Surgeons Glasgow wrote that ‘family pressure is relevant’. The
Royal College of Psychiatrists Scotland said ‘family members feel left out and disempowered following tragic fatalities’.

The Royal College of Radiologists was another that identified the effect of family pressure: ‘Some families are more vociferous...looking for someone to blame...’ Cases involving children were more likely to be ‘evocative’ and therefore result in pressure to prosecute. Conversely, the pressure to prosecute was less in cases where the death involves someone perceived as being of less worth to society as these cases attract less media attention.

Stewart Irvine wrote: ‘Perhaps driven by variability in relatives attitudes and intention to seek redress, or the attitude and actions of police or lawyers who may not understand some of the complexities of clinical care.’

As seen in the above responses from organisations individual medical professional responses also strongly highlight the reaction of the family as being a factor that influences whether a charge is brought or not. We were repeatedly told the following factors of influence:

- Dependent on the personality traits of the deceased relatives - Some people want to get to the cause of a tragedy, some people in grief want someone to blame or have a strong desire for retribution. One respondent juxtaposes two examples:
  
  1. Patient on anticoagulant therapy complained of headaches the day before he was to be discharged home. He died with cerebral haemorrhage. We called the family after death certificate had been given apologised and waited the Coroner's inquest. The wife came to the inquest in a wheelchair and the doctor’s heart sank. The woman did not want the doctor prosecuted, only show remorse and be retrained.

  2. Patient with dementia was admitted because she could not walk with a DVT. She died and the coroner accepted the cause of death. The family took the doctor through two inquiries and he was not found to be at fault. The family pushed again for a third inquiry. Some substandard care was highlighted. The newspapers had a field day.’

- Whether the families feel aggrieved or not. If families are accepting of an event, then prosecution is unlikely. If they are not accepting, a prosecution may occur. Sometimes families say that they want ‘justice’ when they actually mean ‘vengeance’, and their understandable grief sometimes manifests in anger which leads to pursuing individuals who were involved, and interpreting events as causal even if incidental.

- Conflict between relatives and professionals, supplemented by external pressure from politicians and the media.

- The duty of candour about what has happened is likely to put doubt in family’s minds whether the best care was given or not. This will not help them in the grieving process.

- Whether the family contact the police - some will go to the police, others won’t. The advertising of the issue recently probably means more are now aware they can go to the police about an individual health professional.

- Whether the family lobby the coroner.
• Ad-hoc as to how well the family have been treated by a system as to reporting an individual doctor.

• The family's views on compensation and an increasingly litigious culture.

• Does the patient have an advocate or family to act for them - if not then little action is taken.

• Access to criminal lawyers/’ambulance chasers’.

• Certain lawyers’ approaches, ‘untrained defence lawyers’ and whether the lawyers think they can win the case, and occasionally it may be considered in the public interest to hear out the case for a ruling.

• Guilt of attendants/relatives of patients if they have not been caring for the patient themselves, before patient came to hospital. One respondent claims that ‘...in the Jack Adcock case the mother contributed to the death...did her feelings of guilt mean that she pursued the doctor so relentlessly?’

• Relationships between the family and the organisation.

Engagement/communication with the family: the role of apologies and explanations

A few respondents highlighted the importance of explanation and apology in influencing the subsequent feelings/actions from families. Saying for example:

• ‘I have seen bad errors being accepted by the family after an explanation and apology and others that the doctors has been doing their best but a recognised complication occurred the family remain very unhappy.’

• ‘Once an oppositional, combative stance is taken by either party it can be very difficult to avoid an oppositional outcome (eg court).’

• ‘Perhaps because people from the two sides have been able to talk constructively about what happened. Perhaps because key information is withheld.’

• ‘I think its common knowledge that litigation is more likely if the family of a patient feel that they have an explanation, an apology and an expression of remorse from their doctor. There is also an extent to which expectation of outcome of a procedure may be higher or lower. Thus the pre-treatment explanation of risk is also vital to good patient communication and patient satisfaction.’

The role of the media/press coverage and political pressure

Respondents frequently argued that ‘...public pressure/public mood and the media plays a large part in why some fatalities end in charges whilst others do not. Others highlight the social and political context saying there may be ‘political capital’ or ‘local pressure for action’. One respondent says that the ‘Obstetric trainee FGM case’ is an example of when ‘politics gets involved.’

Another adds their view that ‘...More cases of GNM seem to appear in the public domain around times when it suits the government of the day to paint the medical profession in a bad light, eg contract negotiations, NHS reforms etc.’

One respondent adds that ‘...Far from reflecting public opinion, the tabloids in particular are a powerful instrument in whipping up a frenzy of discord about deaths. One only has to
consider the recent Charlie Gard case whereby there were even protests outside hospitals, with a media hyping up and promoting views that were entirely out of accord with clinical reality, to sell papers. I'm afraid that it is quite clear that a doctor with a different skin colour, or some other perceived foreign-ness, is always an easy target for this. A white baby dies and a brown female in a headscarf was the doctor: it's the perfect storm for aspects of the media which represent and fuel an ignorant, racist undercurrent in public discourse. The risk is that a media frenzy is seen as reflecting rather than shaping public opinion, and the call for heads on the blocks results in prosecutions. ‘

**Characteristics of the patient that died**

This comment reflects are more broadly held view that particular characteristics of a patient who has died will influence whether a charge is brought or not.

One respondent argues ‘...It depends how it looks in the public eye. A drug user with a string of convictions will have a different pressure from a white British baby with middle class parents for the prosecuting authorities that may face press enquiries. The cyclist v pedestrian, if the obnoxious young man had been knocked over by the mother of two on her bicycle, likely it would have been judged he should have raised his eyes from his mobile device before crossing the street.’

Another adds whether it is a’...heart rending case. Cases involving children do, or pregnant women, but the elderly just go unnoticed.’

One respondent provides quite a full response on this particular issue which they based on their experience as a member of their hospital’s Serious Incident committee (that reviews all SI reports before they are sent to the CCG). In this response they highlight the seeming disparity in different cases depending on the profile of the patient and family members. They:

‘...it is clear that on a fairly regular basis patients die, in part, due to medical error. The majority of these patients are elderly and a significant number are frail and are in the last few months of life. The fact that they were not reviewed medically over a bank holiday weekend (normal practice unless their NEWS score is elevated), neither had a drip up nor fluids pushed/monitored, had no U&E measurements and went into AKI (which on the whole doesn't elevate NEWS) and then into cardiac arrest is usually accepted by relatives with a 'reassurance from the hospital that lessons will be learnt'. In fact the most obvious failing in a lot of these cases is that no advance decisions (and sometimes not even a DNACPR order were discussed with the patients or their relatives.)

We had one death which was due to the fact that no-one would prescribe a diabetic patient insulin. The FY1 said he wasn't trained, the registrar said he was waiting to hear from the GP about the patient's usual dose, the diabetic nurse hadn't done her prescribing course and no-one thought to involve a diabetologist in the management of a very brittle diabetic who had been admitted in DKA, given sliding scale insulin in A&E and had then had a severe hypoglycaemic episode following which his insulin had been stopped. He was 'down & out', had no family members and although the police/coroner were informed no-one was really that interested.
The situation within paediatrics is, of course, entirely different. There is great potential for an emotionally charged atmosphere, young patient at the start of their lives, children capable of ‘going off’ extremely rapidly and all within an environment not necessarily more protected than in other parts of the hospital although in most hospitals, but not all as Leicester showed, consultants are very hands on and have a strong presence on the wards.

Some years back a young man attended our A&E dept with a headache. Nobody examined his fund. He was sent home and died from raised intracranial pressure. It resulted in an SI but not in an investigation for GNM. Later an optician, Honey Rose, was convicted of GNM for failing to diagnose papilloedema - but of course in her case it was a child.’

**Characteristics of the practitioner**

We were repeatedly told that the race/ethnic background of the accused was a factor that influenced whether doctors are charged or not – ‘unconscious bias often against a BME doctor’. As we have seen in responses to previous questions we were told ‘...there is undoubtedly still prejudice (and racial bias) in our society; people from different cultural backgrounds present information differently and reflect differently after something has gone wrong. We do normalise what we consider acceptable but, in this... we are not truly understanding how someone can be acting acceptably for their culture and find it very difficult to understand what the British culture demands. In some societies admitting failure is unacceptable and this hampers UK style reflection.’

Others indicate that ‘...ethnic appearance,’ ‘language and cultural differences, barriers to communications’ and ‘...heavily accented English all impact on this.’

One respondent comments ‘...If you are a woman society will never support you.’

Dissenting from the majority view, one medical professional comments that they ‘...think there is probably a lack of honesty involved - in Dr Bawa-Garba's case, I think she has been seen as a representative of BME (or of a certain religion) or as a mother returning from maternity leave rather than as a doctor who acted carelessly (even if there were some mitigating circumstances).’

**Luck/fortune/chance or the individuals making decisions**

The word ‘luck’ was used 17 times in online responses, ‘random’ 12 times, ‘chance’ 11 times. A number of respondents thought it simply depended on the individuals involved in making the decision.

Some argue that it ‘probably depends on how the police react to it’ and some say there are ‘...differing standards by local police forces,’ ‘local and regional variations’ or ‘...poor performance by police and prosecution service.’ Another adds that ‘the decision making process is viewed on individual case merits, but does not always seem transparent in either direction.’ One suggests ‘...Perhaps because of lack of resources in prosecution services.’

One respondent commented that ‘...police are trained to view individuals as criminals.’

**Blame of individuals and cover up by employer**
Some said it is ‘...down to the individual nature of the trust- whether they blame or learn;’ ‘probably senior managers and clinicians wanting to scapegoat vs clinical team does not refer case on for investigation’; or, whether ‘the Trust wishes to divert attention from their own failings.’ A few argue it’s easier to blame individuals than for example ‘a lack of resources or funding’ and ‘...there is no political motivation to improve the system and no money so someone has to be blamed to avert the public's attention.’

One respondent claims that ‘...some NHS bodies are more skilled at hiding the evidence (for or against individuals), and murkying the waters too much... In the case of GNM, this appears easier to ‘chase’ over corporate manslaughter.’

Others highlight that it depends on the ‘...willingness of other professionals to point the finger or hang a colleague out to dry to cover their own failings... It depends on the people immediately around the individual who made the mistake. If they are well liked and supported by the team criminal prosecution is unlikely - if they are new to the team when the mistake occurs or if they do not fit into the team they are at greater risk. Do the team wrap around and support or "throw them under the bus". Whether the Doctor is liked within the hospital or is seen as "disposable" such as junior doctors who are on rotation and are easier to replace.’

Similarly others highlight the role of the ‘...benefit of Senior Consultant Expert Witness' advice. Saying also that ‘...the variability in the character and personality of the expert witness’ also plays a role, or 'the extent to which the expert is prepared to say that the error was egregious to both the police and ultimately to the Court is the key variable.’

**Combination of factors**

Some respondents argued that it is due to a combination of factors that some fatalities end in charges whilst others do not, saying for example ‘...Combination of the initial investigation, some cases the police may receive poor or biased independent advice, the nature of the fatality itself, and the context within the organisation is also important.’

Similarly, a family member shares the following response:

- ‘Probably senior managers and clinicians wanting to scapegoat and grieving relatives wanting to blame’
- Racism?
- Poor performance by police and prosecution service?
- Anti doctor feeling?
- Because of the NHS cover up culture.

It is like a lottery. That's why it is unfair. It causes unnecessary distress to families and doctors and nurses. No one benefits.’

**Nature/severity of negligence**

Variations in the actions of the professional(s), the nature of the offence and ‘the seriousness of the error’ are thought by a number of respondents (including NHS Improvement) to be relevant to the decision to charge – ‘...some may be more clearly reckless or egregious. All fatalities are tragic - some are the result of mistakes, some involve a crime and some, both.’
The following factors were considered to be relevant here:

- Clear and inexcusable clinical failings.
- Possible evidence of a pattern (a la Shipman).
- Delay in delivery of care/action by the practitioner.
- The response by the practitioner eg ability to admit error. Cover ups by healthcare professionals of genuine errors when the intent was not too harm.
- Willingness of doctors to discuss with seniors/colleagues/MDOs and access to and acceptance of ‘good advice’.
- Some practitioners are more vulnerable to entrapment-type confessions.
- Practitioners working alone are more likely to have cases going to prosecution as there can be no supporting information to corroborate their actions.
- Medical experts can be inconsistent in their application of the law and the relevant test.

Some of these depend on ‘cultural and personality factors’ we are told.

**Calls for law reform and questioning criminal culpability in GNM cases in the medical setting**

One respondent simply says ‘…Because the law regarding manslaughter in such cases is open to different interpretations and needs urgent overhaul.’

The Doctors’ Association UK reiterate that ‘…the law in Scotland for culpable homicide have the concept of mens rea or ‘guilty mind’. [which] must be present when considering cases of voluntary culpable homicide. Unfortunately, this is not the case in English law and as a result the threshold for GNM prosecution in England we feel is set too low.’ They propose ‘that the law of culpable homicide in England, similar to that of Scotland, would better reflect the pressures on healthcare staff and give adequate justice for patients and their families when affected by such tragic events.’

Others argue that conviction will occur ‘…when all the situational evidence is not placed in front of a court, e.g. dr sellu, dr bawa-garba the jury was led to believe this was a yes/no question, and they will always err on the side of caution, of what they know - ie that healthcare workers must never make mistakes (just as they often let drivers who kill cyclists walk free as they think ‘it could have been me’). Lots of the situation evidence was not deemed permissible which is ridiculous in a complicated multi factorial ‘swiss cheese’ situation.’ Another adds that ‘…criminal prosecutions have little to do with moral culpability and that should be the determining factor in whether or not there is a prosecution. If I kill a patient because I am drunk at work then prosecute me for gross negligence manslaughter. If I kill a patient because I am simply incompetent then sack me and strike me off the medical register but don’t prosecute me for a criminal act.’

**General feedback about GMC**

There were many respondents who left feedback and general criticisms about the GMC in responses to this question. These responses included:

- The GMC no longer applies reasonable doubt as its standard, rather the balance of probabilities. In my opinion - this is wholly and completely unfair. It is neither in the best interests of patients or doctors. (Or the GMC/MPTS)
- Since the Shipman Enquiry, the GMC has become a draconian anti-doctor organisation with processes not unlike the Spanish Inquisition. It’s hostile attitude towards doctors is despicable and renders the organisation not fit for purpose.
The GMC are woefully inadequate and are not consistent in their behaviour towards doctors who are reported to them. I have personally raised concerns about doctors and been astonished at their lack of response.

In a way why is this relevant - an individual case may carry the burden of GNM/CH however the GMC must balance the risk to public safety (not confidence) posed by that case i.e. does the individual carry an ongoing increased risk above the average clinician of causing harm? That would be my concern about the GMC's response to the recent case that they seem to have responded to perceived public populism as opposed to objective decision making based upon the individual and individual case - shame on the GMC - at face value they have failed in doing their duty - with power comes responsibility - that responsibility sometimes means taking tough unpopular decisions because they are right.

Reduce GMC powers

I think, as do many doctors, that recently the GMC appears to be going to unnecessary lengths in what it considers "public interest" and has lost sight of improving patient safety. It is wrong, and indeed harmful, to pick on individual doctors as scapegoats when the system is sick and goes untreated.

General Dr Bawa-Garba case feedback

There were also a number of respondents who left comments/feedback and criticisms in relation to the Dr Bawa-Garba case:

- No healthcare worker who is trying their best in often suboptimal conditions should ever feel that if they act in good faith they risk criminalisation or losing their livelihood.
- If the key public interest is improving public safety as opposed to victimising a professional then surely professionals ought to be offered remediation and a chance to prove they have learned through the painful process. Increasingly as of late the professional feeling is that public and political interest has been used to crucify individuals without looking at the wider picture and by leaving other important factors unharmed (the consultant in Bawa Garba's case who was teaching at another hospital on the day they were meant to be on call; why had they not arranged for a colleague to cover them? The ICU registrar who was on leave; why was there no proviso for someone else to cover their post on the day? Where in Bawa Garba's case did the GMC ruling appoint blame to the system and sought to apply justifiable sanctions to the group of people (and I include rota managers) who were meant to be supporting the junior doctor at work on that fateful day? Until the GMC and other professional bodies demonstrate that there is fairness and impartiality in their judgment and that no one is beyond punishment, no matter how senior they are, the profession will continue to distrust them.
- The Bawa Garba case has affected me on a personal & professional level. As a doctor I fail to understand what actions that day constitute a criminal act. I see an overworked, unsupported doctor fresh back off maternity leave covering multiple wards & units with no access to test results trying her best with several critically sick children. There was a Swiss cheese model of multiple errors/failings which culminated in a disastrous outcome for all involved.
- This case makes me want to give up my job in the current NHS. If I was younger I'd emigrate & if older retire. We are reaching a critical mass for the current health system collapsing due to staff recruitment & retention. That is not in societies interest & not what the public want.
- I qualified in 1996 & it never crossed my mind as a law abiding citizen I could be made a criminal for human error in a profession where risk is inherent. I now think about it every shift & it frightens me. It makes me practice defensively & not take risks I would have accepted even a year ago. If she is guilty of GNM every single doctor in the UK could be next to face prosecution.
- She was punished for the outcome not her actions. If the exact same sequence of events occurred but Jack survived the case would not exist. People have made more serious errors...
but without a fatal outcome it is not impacting on their livelihoods & their reputation is not being destroyed by mass media.

- We will not own up to near misses due to fear of prosecution for adverse events therefore losing vital learning opportunities.

- A once off avoidable death in an otherwise unblemished career should not result in destroying the healthcare workers involved careers. They would never make that mistake again & would be safer clinicians as a result of lessons learned.

- To qualify as homicide through culpable negligence, the law in England requires a practitioner to have exhibited an unusual and recklessly high degree of risk. In Scotland, the law is different in that it requires a consciousness of the risk to be present. In the words of Scottish case law, the risk taken must be intentional as well as reckless or grossly careless. So there is no doubt that Bawa-Garba would not have been indicted if she had worked in Scotland. She made a mistake, a series of mistakes, that accumulated in a disaster, but none of them was intentional, and quite a few were due to factors beyond her control.

- ‘...the Bawa-Garba case, was so grossly, even grotesquely, unfair.

- If you put someone in a situation of unmanageable pressure, they are bound to make mistakes. If they are managing 3 times their normal workload, if they have not got the tools that allow them to do their job properly, if they are let down by their colleagues, then why should you be surprised that mistakes happen. You should be surprised if they did not happen. If you then judge them through the mind-set of an expert looking at their performance with hindsight in abstract, you are, to put it simply, being unfair.

- Yet the GMC, in its guidance to tribunal members says that they should put context one side, and judge each situation as an individual event. That means very little to the doctor with 30 patients buzzing in his waiting room, a teenager threatening to take an overdose on the phone and a chest pain coming to reception. He has to prioritise, to make judgements, and it is only hindsight that tells us whether those judgements are correct. If a decision made at the end of an exhaustingly busy 14 hour shift is, with hindsight, very wrong, why should we be surprised? And why do we think it is constructive to hang the doctor who made the mistake, however bad it’s consequence, out to dry? This is not about competence, as we learnt in the Bawa-Garba case, it is about context.’ (Dr Tim Howard)

- The Doctors Association - The recent actions by the General Medical Council however to appeal the MPTS decision in regards to Dr Bawa-Garba has severely damaged the relationship between the GMC and doctors. The pursuance of erasure of a BAME doctor to such extremes seems disproportionate in light of previous GMC behaviour. The case of Dr Barton, a GP working at Gosport War Memorial Hospital, shows the GMC acting in a completely different manner. The independent panel report reveals how the GMC at the fifth Interim Orders Committee felt that its investigation was being used by families as a way at getting back at Dr Barton. In fact, it was only at the fifth Interim Orders Committee hearing that any restrictions were placed on Dr Barton and that those restrictions were essentially identical to those previously voluntarily agreed to by Dr Barton herself. In recommending a 3-year order with 11 conditions the General Medical Council did not sanction erasure from the medical register. There was a recognition that the GMC “noted that Dr Barton was operating in a situation where she was denied the levels of supervision and safeguard, guidance, support, resources and training necessary to ensure that she was working within safe limits.” It appears that the same considerations were not made when considering the case of Dr Hadiza Bawa-Garba thereby raising the question as to whether BAME doctors are treated differently by the GMC.
**Question 41. Under what circumstances would it be more appropriate to consider cases involving fatal clinical incidents within the regulatory system rather than the criminal system?**

There were 406 responses to this question online.

The vast majority of respondents said that most or all cases should be considered by the regulatory system rather than criminal system. As we saw in responses to the opening section on what people perceive to be criminal acts they viewed criminal cases as those where there has been recklessness, deliberate harm or intent on behalf of the doctor. The words ‘intent’ or ‘intention’ were used 78 times, ‘wilful’ 11 times, and, ‘deliberate’ and ‘deliberately’ 50 times. Generally, respondents viewed the criminal system as (and should remain as) ‘...a final option, even in incidents investigated in the regulatory system.’

Three family members or patients agreed that the regulatory system would be more appropriate than the criminal system in most or all cases. Again, one said ‘unless there is intent.’ Another of those that agreed said, ‘...If a staff member has followed trust policies in place to protect patients, even if they have missed opportunities to intervene to save a patient due to environmental pressures but their actions did not directly cause the patient’s death they should not be prosecuted, this type of error should be dealt with by the regulatory system in a meaningful and robust way.’

One simply said ‘...All cases should be reviewed by external bodies.’ But did not say which bodies they were referring to.

It was suggested that these types of cases should be dealt with in a similar way to the transport industry (no blame culture). One participant recommended conjoined investigation by the GMC with the police service.

One respondent believes ‘...the regulatory system is always the appropriate one for protecting the public. Anything less destroys faith in risk management and mitigation/clinical safety as being a neutral sphere to protect the patients without scapegoating individuals.’

Another respondent argues ‘...If properly applied, criminal investigations/prosecutions should be reserved for only the most significant and culpable errors which are truly exceptionally bad in all the circumstances. In all other cases, there are already a number of mechanisms for investigating fatal clinical incidents including Coroner’s inquests, at the conclusion of which the Coroner is free to recommend further investigation by a regulator if necessary. The same applies in relation to fatal Accident Inquiries in Scotland. A regulator should only open an investigation where there is a realistic prospect that a clinician’s fitness to practise may be found to be impaired as a result of the incident. Again, this decision should be taken with an appreciation of the surrounding circumstances.’

A Medical Director/Responsible Officer advises that ‘...One might argue, that in any case where there is doubt, it would be better for the case to be considered at first instance by the professional regulatory process, and that only if that process identifies truly bad practice, should it be referred to the criminal justice system. The problem with this would be the potential for individuals to incriminate themselves if they are fully reflective in the
A professional regulatory process. However, it is equally perverse to some extent, that the GMC has to await the outcome of a criminal process (often taking years), before reaching a conclusion on fitness to practice. It is difficult to conceive that the GMC could reasonably not find that fitness to practice has been impaired, if a doctor has been properly convicted of GNM.’

The Royal College Psychiatrists Scotland stated that the ‘approach to culpable homicide in Scots law is one which embeds principle and proportionality.’

A member of the legal profession advised that ‘...the regulatory framework should assist the court to understand the standards expected within a profession.’

One respondent thought that there should be an independent panel to consider these cases and that ‘...there should be a meeting of systems to consider and think through the implications of these very rare cases... The processes necessarily inform each other, but the independence of legal frameworks is vital and in the public interest to be maintained. The professional regulatory system should inform the other system and vice versa, but there may be very significant and unusual situations where this does not occur effectively or logically, and an unsatisfactory or what appears to be an unjust situation is reached, and this was clearly the perception in the Bawa-Garba case.’

The Royal College of Obstetrics and Gynaecology (RCOG) say ‘...Given how much work is being undertaken by the GMC and CQC in supporting staff in relation to patient safety, it is vitally important that work such as NHS Improvement’s “a just culture guide” are better joined up and promoted. In light of the Sir Norman Williams Review, it is understood that this tool will be reviewed. The RCOG would urge that this is updated with any changes made to regulators and that there is consistency with all arm’s-lengths bodies, trusts and health boards about the correct processes following clinical incidents.’

**Under no circumstances would it be more appropriate for the regulatory system**

Some family member or patient respondents dissented to the majority opinion saying ‘...Under no circumstances. Gosport is proof of that because the GMC failed and took 8 years over their case apparently. The GMC aren't tough enough.’ Similarly, another family member or patient lacked faith in the GMC as well as the criminal justice system, saying ‘...makes no difference -The law is only as good as the integrity of those entrusted to administer it.’ Another adds that ‘...All fatal clinical incidents should be considered under criminal legislation. There should be no double standards over the cause of an unexplained death.’

Another family member or patient seemed to agree that they didn’t trust the regulatory system, saying ‘...If in truth a regulatory system would exist, a criminal system would not be required for such cases, but the lack of it creates another unjust system, Criminal system, which exists for the normal citizen only, but not for the big organizations runned by our own Government who is at the core of these unjust system!’

Finally, one family member or patient advised that this is ‘...A question we would all like to know the answer to.’
Independent review of gross negligence manslaughter and culpable homicide
**Question 42. What is the role of independent medical expert evidence in criminal investigations and prosecutions?**

There were 328 responses to this question online. 13 respondents said ‘unknown,’ seven said they were ‘unsure’.

**The ‘role’ of independent medical expert evidence**

There were a number or recurrent themes identified in responses to previous questions about the role of independent medical expert evidence in local investigations and inquiries by the coroner or COPF, in particular issues around independence, training and accreditation. Ten respondents directly referred to their responses to those questions, to say that the same applied here.

We saw again here that respondents believed that the independent medical expert’s role is to ‘assist the court’/‘to offer clarity to lay men’ and give their opinion on:

- the cause(s) of death
- whether the treatment was causative in the death of the patient
- whether there are understandable reasons for why a particular treatment/non-treatment cause was considered
- the role of mitigating circumstances
- if it was reasonable for the doctor involved to consider the alternatives e.g. would a doctor of similar training, level of support and workload have come up with alternatives.

There was general consensus that the role of independent medical expert evidence, particularly at this stage is ‘paramount’/‘essential’/‘pivotal’ in terms of whether a prosecution and conviction is secured. One patient or family member simply says ‘...critical’ and another just says ‘...vital’. Respondents highlight that ‘...prosecutors and the courts must rely heavily on interpretation of very complex and specialised information in order to reach a judgement.’ And say that ‘...there is a similar situation when dealing with complex IT or fraud issues.’

We are reminded here that ‘...the contribution of an individual to a particular poor outcome cannot be appreciated without a detailed knowledge of the difficulties in diagnosis and assessment, the treatment options and their practical difficulties, environmental factors compromising care and the treated and untreated prognosis.’ A Medical Director/Responsible Officer warns that ‘...obtaining appropriate expert independent advice is likely to become increasingly problematic,’ due to increasing sub-specialisation for example.

Some respondents queried the definition of ‘independent’ medical experts as they believed an expert acting for the prosecution could not possibly be independent and this is why the defence will instruct their own expert (one respondent thought that this was not the case in civil cases and that the experts in those cases act independently for the court). A respondent says for example, ‘...experts need to realise that their duty is to the court. Unfortunately due to the adversarial nature of the court, this is often forgotten.’

**Issues with medical expert evidence in criminal proceedings**

As we have seen as a recurrent theme to the previous questions about the role of independent medical experts in local investigations and inquiries, again the Colleges all
appeared to demonstrate concern over how experts were selected and raised concerns about their consistency – specifically with regards to having up to date clinical knowledge.

We are told that ‘...The conduct of expert witnesses is variable... some have more knowledge of the law and legal processes than others.’ The Doctors' Association UK would ‘...suggest that every medical expert witness undergoes minimum training which includes human factors, legal report writing as well as training about criminal law and the law in relation to GNM. A register of expert medical witnesses should be kept by the medical royal colleges. The provision of expert medical evidence should be declared as part of a 'whole practice revalidation’ and should be assessed by a suitably qualified expert nominated by the medical royal college.’

**Reliability and nature of medical expert opinion**

A medical professional comments that ‘...The nature of medical experts is that there will always be more than one school of thought and it eventually boils down to who is more convincing on the day in court! This is the fallacy in our judicial system.’

Professor Ian G Finlay (Scottish Government) similarly advises that ‘...The expert evidence is the key to the Prosecution. Without it there can be no Prosecution. Experts vary in personality and character. There are "hawks" and "doves"...the expert is asked to agree in Court that the Defendant's behaviour was sufficiently egregious to merit conviction. This is very emotional and compelling for a Jury who have no medical knowledge.’

Again The Doctors Association UK also believe that whilst ‘...the court expect that they will provide their opinion of the facts presented... there are considerable differences in the quality of medical expert witnesses. Unfortunately, a jury often makes a decision based upon the performance of expert witnesses in court and therefore it is imperative that they are given the correct guidance when making the final decision about the verdict.’

**The expert’s role is not to give an opinion on whether it is gross negligence**

Dr Jenny Vaughan tells us that experts have ‘...too much power. Lay juries often are presented with reams of scientific papers which we know would challenge many of us’ Dr Vaughan cautions that ‘... Expert evidence should not trespass into the role of the jury in deciding criminal cases...Their duty is to inform the court/inquest/hospital SUI in an impartial manner as to the medical aspects of the case in a way that people can understand it and accords with the known medical norms and indicate how far there was any departure from accepted standards of care. They must be impartial.

Dr Oliver Quick highlights that ‘the causation question is more obviously concerned with forensic science and pathology, with explanations about possible causes of death. But the ‘gross negligence’ question requires medical and moral judgment. It is an evaluative term which requires moral assessment of the conduct (and, crucially, the character of the defendant...) Whilst it could be said that medical error is potentially an observable phenomenon fit for scientific enquiry, there is no established science of safety in medicine. The systematic study of error and safety is emerging rather than established and there is no consensus for measuring which errors are excusable or inexcusable. Given the absence of safety science in relation to medical work, and the lack of an objective method for
classifying conduct as ‘gross’, the current system thus relies on expertise by experience, with experts exercising moral judgement on whether conduct crosses what sometimes feel like faintly drawn fault lines of criminal law. In other words, the opinion evidence of experts.’

Dr Jenny Vaughan reiterates that ‘...expert witnesses should not be stating whether they think the case is gross negligence - that is something for a jury to decide.’ Dr Vaughan refers to Dr Quick’s former observations that ‘...there is the risk that experts potentially lose independence and impartiality whilst being swept up in the adversarial legal system.’ And ‘risk that particularly charismatic, confident experts might appear to be determining the ultimate issue and a risk that juries may feel that they are being told “This is grossly negligent, therefore you should convict the defendant” [Dr Vaughan left this comment in response to a previous question but it appears more fitting here as it relates particularly to criminal investigations].

A retired doctor and ‘independent legal scholar’ also advises that ‘...Medical experts (particularly importantly the first prosecution expert) often fail to understand the three different levels of negligence: (1) simple negligence, sufficient for a civil claim; (2) serious negligence, sufficient to call into question fitness to practise; and (3) gross negligence, which lies a long way above the others and is needed for manslaughter. Experts in fitness-to-practise proceedings are often asked to distinguish (1) and (2): “Did this conduct fall below or well below the expected standard?” Sometimes it seems the same standard is applied in initial reports for gross-negligence manslaughter cases (resulting in unnecessary prosecutions), and later before the jury. In this situation the test (3) is something such as "truly exceptionally bad" or warranting a criminal conviction and sanction, not the much lower serious negligence test (2).’

‘The law itself is fatally flawed and must be changed.’

One respondent draws on the case of the nurse, Anne Grigg Booth, saying that ‘...the police and prosecuting authorities were strongly influenced by the highly flawed evidence of a single opinionated expert witness for the prosecution; at the inquest into Grigg Booth’s death, the witness admitted that, in the same circumstances, he would in fact have acted in the same way as did Grigg Booth. The evidence of the expert witness for the prosecution in the Bawa Garba case was shockingly poorly structured and argued; its effect on the jury was influenced by the way in which the evidence was organised by counsel for the prosecution, concentrating on the emotional evidence of the irrelevant error related to the resuscitation procedure.

It’s hard to see how this can be ameliorated and how systems of quality assurance of expert evidence could be introduced. The law itself is fatally flawed and must be changed.’

**Quality Assurance/accreditation or training**

We were told that medical experts should be ‘routinely challenged on their opinion’. It has been suggested that a quality assurance programme and/or training for expert witnesses should be implemented. This was because there was some concern raised that medical experts are often instructed because they provide the opinion deemed appropriate by the hiring agency.
Unrealistic opinions by specialists/non-specialists and lack of recent, relevant clinical experience

One patient or family member believed that the role of the expert is ‘...to provide evidence of how someone would have been treated from a best practice perspective.’

However, there was emphasis added from most respondents of the need for them to reflect the standard of the accused doctor in all the circumstances they found themselves in and the need for expert witnesses to have experience in the current clinical environment, reflecting current standards/guidance. As we have seen in responses to previous questions about independent medical experts, respondents raised concerns about selection and use of appropriate experts. For example, a medical professional who tells us they act as an expert witness argues that ‘...the specialty associations, who have a much clearer idea of an individual's credentials and qualifications to be an expert witness, feel that the process by which this is done by legal teams up and down the country is inadequate. Offers have been made to help with this task but these have been rejected as not being central to the legal process. A result of this, for example, is that surgeons who are many years retired and therefore could not possibly know about the current practices and rules ... continue to give expert evidence for both the prosecution and defence...I am frequently asked to give an opinion on pelvic floor problems. Legal teams seemingly do not know that I am not an expert in this specialised area. As I do not have a specialist pelvic floor practice I always refuse to give such an opinion, but there are no recommendations or rules of conduct to prevent me from doing so.’ However, they do not provide any further detail on what they are referring to in terms of the offers made to help that have been ‘rejected.’

Expert advice on corporate liability/ system accountability

One respondent shared their personal experience of a case of GNM, as an Expert Witness for the Defence, where ‘...the Court was not prepared to consider corporate responsibility for the patient's death. A joint disposition from myself and an expert from an academic department specialising in the theory of accident causation and clinical risk management was regarded as inadmissible in mitigation of individual culpability and the case was deemed indefensible by Counsel. The accused was incarcerated but interestingly, after release, restored to the Medical Register after examination by a Fitness to Practise panel of the GMC.’

Dr Jenny Vaughan (as well as a couple of other individual respondents) also refers to the issues with medical expert evidence in the case of Sellu. Dr Vaughan says that the first expert instructed in the case found ‘no GNM... [and the case] should have stopped there. CPS then instructed another one who did.’ She says that then there was a ‘...meeting of the experts’ who ‘...concluded 'systems failure'. Then there was a change of stance by [the] main expert on 8/9 points.’ Dr Vaughan believes the case (again) ‘...should have stopped there.’ She highlights that ‘...experts [are] part of [a] faulty process eg statistical scoring system used wrongly. A recent 'Justice Gap' paper found that misleading scientific evidence presented at trial drove hundreds of criminal appeals against convictions.’ Dr Vaughan adds that in the trial the ‘...experts dealt with the ultimate point...A jury in 2013 found David guilty of a criminal offence, yet an MPTS panel in 2018 found no misconduct against him in the same case...A highly significant change in the way a serious part of the law was applied.
was achieved at appeal...More emphatic directions given by the Appeal Court in the case will assist juries regarding the high threshold for gross negligence manslaughter.’
**Question 43: How are independent experts selected, instructed and their opinions used? Is access to appropriate expertise always available? Do they have training in unconscious bias?**

There were 314 responses to this question online. 14 respondents said ‘unknown’ and 12 were ‘unsure.’ There were a number of respondents that directly referred to their responses to the questions about the selection/instruction and use of experts in local investigations and coronial/COPF processes, to say that the same applied here.

As we saw in responses to previous questions on medical experts, there was widespread concern expressed about the selection, use of and ‘deficiencies’ of/quality of medical expert advice in (criminal) proceedings and expert’s lack of independence.

There was a consensus from some that instruction of medical experts was reliant on medical expert’s own self-promotion, based on their reputation or opinion (which can be seen from publications/articles) and through word of mouth recommendations.

**Experts selected are not perceived to be ‘independent’**

One patient or family member told us that ‘They say they have [instructed an independent expert] but PHSO [the Parliamentary Health Service Ombudsman] expert witness was a member of the same club that one of the consultants that was being investigated headed up! The patient has no choice.’

**Opinions are ‘bought’**

The Doctors Association UK was one of many organisations to question the impartiality of experts, referring to ‘a widely held belief that expert witnesses are hired to support a specific narrative’ and that experts can be found ‘to argue almost any position the CPS has and wishes to prosecute.’ Stuart Irvine (for NHS Education Scotland (NES)) made a similar point, but seemed to go further: ‘those investigating and prosecuting cases are prone to select experts who espouse a particular view…yet fail to share this fact with the courts.’

Professor Ian G Finlay (Scottish Government) says that the ‘...most disturbing aspect of the current system in England is that the Prosecution can and do "shop" for an expert who will give a supportive opinion and that this fact is not declared to the Jury. In effect supportive evidence for the defendant can and is being concealed from the Jury.’

**Unrealistic opinions by specialists/non-specialists and lack of recent, relevant clinical experience**

As we have heard recurrently in answers to previous questions we are reminded that jurors (and lawyers) place great reliance on medical expert evidence in criminal cases of GNM and there is a perception from some, that expert’s opinions can be bought or that they can be retired and out of touch with the current pressures that doctors work in. Some say they are selected and instructed in a variety of ways. Word of mouth recommendations are common. Some highlight (again) the issues with medical expert evidence that arose in the overturned...
conviction of Dr Sellu. There have been reports that the first expert evidence provided for
the prosecution found little to criticise and so they were dismissed and they instructed the
second expert who was retired. 34

Training for experts

As we saw in previous responses most respondents thought that ‘...it is most unlikely that
these people would have any training in unconscious bias.’ Many also thought that training
for expert witness and especially the use of unconscious bias would be beneficial. However
one medical professional (a consultant neuropsychiatrist) believed that ‘...training in
unconscious bias not required at present and we should be very cautious indeed about such
training and somewhat flaky concepts from psychology.’

We heard from medical professional who was also a trained expert witness. They expressed
concern that there was no transparent way of recruiting or employing expert witnesses. It
was noted by some of the medical profession that appointing an expert witness often relied
on the expert witness’s relationship with the legal team.

The broadcaster Nick Ross says that ‘...unconscious bias is a very much larger problem in
court cases than is generally understood. The UCL Jill Dando Institute has expertise in this
field, and you might care to hear from Dr Itiel Dror who is a world expert in how scientific
evidence is contaminated.’

A member of the legal profession argued that ‘...training in cultural appreciation would be
beneficial.’

The Academy provided an in-depth submission on selection and use of experts (highlighted
in the analysis to the previous question about selection of experts in coronial proceedings)
and noted earlier attempts alongside stakeholders such as the Coroner’s service to create a
list of experts which met agreed standards.

There have been suggestions from some colleges that a cadre of skills for expert witnesses
would be beneficial. The Royal College of General Practitioners believe that given gross
negligence manslaughter cases are rare, it would seem reasonable to have a panel of
relevant medical experts which the Coroner’s Court and CPS could approach. This may be
by application and appointment, whereby experts on the panel must prove their fitness to
fulfil the role for the case. It would seem reasonable that any such expert should have a
licence to practice from the GMC and be in active practice or within three years of
retirement, to qualify for the role.

It is important to note that the Academy is due to develop Quality and Assurance
framework on the skills required for expert witnesses.

It appears that (from their submission) that the BMA (England) would agree with all parties
having a common and shared agreement. They also recommend that ‘...that it should be

34 The expert medical witness: the good, the bad and the ugly, Peter Mcdonald, trends in men’s health,
mandatory for all expert witnesses to undergo core training in medico legal report writing, courtroom skills, cross examination and criminal law and procedure. This would provide the basic necessary competencies and confidence required to work efficiently as an expert witness.’

The MPS have also stated that ‘acquiring the skillset to be an expert witness should be included in the training of consultants and GPs. NHS employers could take steps to make it easier for doctors to be relieved from their clinical duties so they can act as expert witnesses. This may require contractual reform to give the expert witness role greater prominence. In addition, we would encourage more doctors to consider putting themselves forward to perform expert witness duties.

We require competent and credible doctors who can present balanced evidence in the context of delivering healthcare in a modern day NHS. MPS provides support to members who undertake the expert witness role as we recognise that it is one of the core duties of a doctor. Secondly, expert witnesses should receive appropriate training to understand their duties to the court. MPS has experienced witnesses give evidence where they appear partisan. As noted above, it is for the jury to decide on whether the breach of duty should be considered ‘gross’. However, it is for the witness to assist the court in understanding the standard of care delivered by an ordinary competent doctor and whether in their opinion, it was met.’
Question 44. Do the same standards and processes for experts apply with regards to evidence provided for the police or prosecuting authorities as they do for a local investigation, an inquest or fatal accident inquiry process? If not, why not? For example, is there a higher level or different type of expertise or skill set required?

There were 296 responses to this question online.

- 31 respondents referred to the answers they had previously given to this question elsewhere in the survey, in relation to standards and processes for experts in local and/or coronial investigations.
- 163 respondents said they don’t know, N/A, or other words to the effect of it not being within their knowledge or experience, and without giving a view as to what they thought it should be.
- 10 said no, the same standards and processes do not apply.

Whilst there was mixed views expressed about whether the standard should be higher for criminal investigations or the same, overall there was recognition that it would be desirable for the same standards to apply (including for example the interpretation of the evidence ought to be the same irrespective of circumstance). And that higher level training or expertise would be desirable for those involved in criminal prosecution cases or more complex cases. They expect that more time should be given by experts in providing opinions in criminal cases, where the burden of proof is higher than civil.

One respondent suggests that ‘...It may be that the more high profile the case and/or the more public interest there is in the case the higher the profile of the expert witnesses used for their credibility to all concerned and in particular the media as a proxy for the public.’

As we saw in the responses to the question about whether the same standards apply between local investigations and coronial/COPF proceedings, respondents highlighted that in local investigations the experts are locally appointed clinicians. Whereas, responses suggest that ‘higher [ie criminal or regulatory] investigations look for nationally recognised experts based on experience and reputation.’ They add that ‘...a higher level of scrutiny is applied to the same evidence as you move up the legal system hierarchy. This changes the skill set required of the expert providing the evidence/opinion.’

A Responsible Officer respondent describes the situation by saying that there are ‘three levels’:

1. local investigation - purpose primarily to improve processes for the future and may discover a flaw in process or practise which may not in the individual case have been causative but clearly needs to be addressed, secondarily to explain what happened to relatives and reassure them where faults did occur that steps to improve are being take. Evidence taking neither structured nor rigorous.
2. inquest and fatal accident - balance of probability about how the person came about their death, not proving one person’s responsibility.
3. prosecution - beyond reasonable doubt evidence collecting to a totally different standard for which internal investigations are not designed and for which local investigators and experts are not trained.’

They add that ‘...incidentally this difference can also mean evidence and expert opinion
taken for a local investigation of an incident does not meet the requirements of the GMC investigations team.'
Question 45. Are there quality assurance processes for expert evidence at this stage, if so, what are they?

There were 293 responses to this question online. 18 respondents said ‘unknown’, 5 said ‘don’t know’, 13 said ‘unsure,’ 8 said ‘not part of their experience,’ 12 said ‘no idea’ with one of them saying:

‘No idea how the courts assure themselves of the quality of advice they are hearing. In many cases, it depends on the legal team what questions are asked, and what bias experts end up conveying in their responses to these questions.’

Some respondents referred to their previous responses to the questions about QA processes at the earlier stages of the process which they say apply here too.

One respondent said the ‘...quality team do assess but member skill sets, experience, training and medical knowledge differ.’ Presumably they are referring to the healthcare organisation’s quality team, which would probably not be applicable at the criminal investigation/trial stage of the process.

Another respondent advises there are none ‘...beyond critical examination of such reports by both parties (prosecution and defence).’

Another says ‘...Experts are aware that they can be sued for sub-standard practice, and will have prepared evidence of appropriate training to help in this eventuality.’

One respondent simply puts ‘...Expert witnesses should provide the same level of expertise as in other judicial processes and must be aware that their duty is to the court and not to either party.’

A respondent highlights that ‘...the GMC do some quality assurance of their experts but the process is obscure...in civil and to some extent criminal practice the expert who convinces the judge is the one most likely to be further employed, if that can be called a quality assurance process. Another similarly says that ‘...the legal framework should be the QA process.’

We were told that a respondent that an NHS England expert present at NCAS training stated that QA processes were being developed in 2017. However, we have not received any other responses about this.

Most other responses were that they were not aware of any mechanisms of quality assurance at this stage, including MDDUS but they ‘...would certainly welcome the introduction of such processes in order to ensure that experts used in criminal cases are suitably competent and capable to act.’

Another adds that ‘...there is a need for quality assurance processes, involving the surgical royal colleges and specialty associations.’

A method of assurance that was proposed by a respondent was for more than one expert to be instructed and their opinions sought. This respondent also thought that experts ‘...should have their independent medicolegal work regularly peer reviewed as part of their appraisal process.’ However they also ‘...suspect that this does not always happen.’
Independent review of gross negligence manslaughter and culpable homicide
Question 46. What lessons can we take from the system in Scotland (where law on ‘culpable homicide’ applies) about how fatal clinical incidents should be dealt with?

There were 300 responses to this question online. Many respondents felt they did not have enough understanding of the law to provide a comprehensive answer, this includes 17 who said they were not ‘familiar’ and 16 who said ‘unsure’. However some did support the Review’s intention to compare the two systems.

Generally respondents viewed the Scottish approach as favourable to that of England and Wales, saying for example:

- We can learn that there have been ‘far fewer prosecutions’ and no convictions of doctors for CH and there is ‘no public disquiet from that.’
- ‘seems to have a better system, certainly no high profile cases like Bawa Garba, or shocking miscarriages of justice like David Sellu, who was imprisoned in a maximum security jail, only later to have his name cleared. This stops people wanting to work in medicine.’
- ‘There have been no reported controversies in Scotland of the nature we have seen in England - Scotland is a less litigious society in general, as evidenced by much lower indemnity costs for GPs.’
- The Scottish system ‘...reassures doctors more that they will not feel unfairly targeted. Cases which are into the system are probably suitable to be there. Appears to have more scrutiny before decision to prosecute is made.’
- ‘The Scottish system, is far less terrifying than the English system. I think the Crown Office (Lord Advocate) has to approve the prosecution, and this decision is taken by highly qualified higher ranking officials.’ ‘...relies on an independent legal representative to co-ordinate an investigation.’

Two patient or family members also thought that the Scottish system ‘seems fairer’ and ‘should be adopted across the UK’.

The difference in the law of CH and GNM: mens rea and public interest

A number of respondents highlight the differences between the law of CH and GNM. They say that ‘the threshold for bringing charges is much higher’, ‘is subtly different’ or that Scotland has ‘...a far more appropriate threshold’ than GNM in England, requiring ‘intent or recklessness’. For example, a doctor in training highlighted that ‘...the Scottish system includes a key caveat: CH requires not only subpar performance but also “indifference or disregard to the consequences”. In a stretched NHS, this almost automatically protects a junior doctor who finds themselves covering several people’s jobs during IT problems and other obstacles: if they were doing their best despite the circumstances then they were not being truly negligent, even if the results of their work were not at the standard expected.’

The Scottish Independent Hospitals Association argue that if the [Dr Bawa Garba] case ‘...occurred in Scotland it would likely have led to a verdict of death by misadventure and would not carry a jail sentence. It seems an anomaly that there is disparity for doctors across Scotland and England, when the GMC is a UK-wide regulator.’

The Doctors Association UK (DAUK) adds that ‘...in Scotland the prosecution of a healthcare professional for culpable homicide has to serve a public interest.’

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The Royal College of Physicians of Edinburgh point to the MPS article\textsuperscript{35} which supports a move towards the adoption of CH in England and Wales.

We are also told by a respondent that criminal cases in Scotland require corroboration of evidence; that affects sufficiency of evidence for prosecution. Scotland and England differ too in relation to police interviews. In Scotland, where no adverse inference exists, the caution and the right to remain silent mean that there would rarely be any circumstances where a doctor accused of culpable homicide would be advised to provide any explanation of their conduct. Any explanation may produce the necessary corroboration.

**Adopting law of CH not necessarily appropriate/helpful**

One respondent dissented from the majority opinion (who thought that the systems and Scot’s law of CH were preferable and should be applied), saying that they ‘...did a case in Singapore where the former British India Act applied and which I think is roughly the same as Scotland. It seemed heavy handed, inconsistent and with little understanding of how errors occur or the systemic aspect that may be involved, let alone providing for specific training for the doctor or applying any lessons to the system as a whole.’

Another medical professional respondent just said ‘...they need to change the law there,’ but provided no further explanation. Another respondent highlights that the Scottish Law Commission’s 10th law reform programme is considering homicide (potentially including the legal test for culpable homicide), and may also consider medical deaths.

MDDUS warn that ‘...the key point here is that there must be BOTH truly bad performance AND indifference and disregard for the consequences...some consider that this is indeed the case in Scots Law, although we also note there is little case law to this effect, and hence we cannot be certain that this is the way in which any individual matter would be resolved. Therefore... the review should seek to identify necessary changes to primary legislation in all UK jurisdictions to remove ambiguity, rather than wait for the evolution of case law.’

Dr Jenny Vaughan highlights ‘...Lord Leveson’s decision in David Sellu’s appeal’ which ‘...ensures that judges must direct juries very tightly: the standard has to be that the defendant acted in a “truly, exceptionally bad” manner. In Honey Rose’s appeal it was clarified that there must be foreseeability of death for the negligence to be of criminal degree. The bar is thus higher now, and since these appeals, no further healthcare practitioners have been charged with manslaughter. Several investigations are still ongoing, although since the successful Sellu appeal this number has fallen significantly. Legal refining of GNM means that trying to adopt the Scottish law of culpable homicide (CH) is unlikely to reduce the numbers of healthcare professionals (HCPs) being convicted. There are other factors in the Scottish legal system which should be explored in order to promote learning.

To date no healthcare professional has been found guilty of the offence of CH: there is far less of an appetite for prosecuting HCPs north of the border.’

**Approach to learning from deaths**

One respondent suggested that the zero prosecutions for CH was due to the fact that Scotland have a no-blame culture and their healthcare system is less litigious. Another said we can learn that in Scotland they ‘...consider professional duties and inherent risks.’

The Faculty of Intensive Care Medicine & the Intensive Care Society says that ‘...the Lord Advocate must also authorise the pursuing of the prosecution as being in the public interest, which may be interpreted as likely to promote patient safety and prevent such acts occurring in the future.’

Another medical professional shared their view that ‘...whether we call it culpable homicide or manslaughter it makes no difference to the professionals’ eyes... What matters is how we learn from inevitable mistakes and ensure no lives are lost through repeated errors that could have been prevented.’

DAUK ‘...feel that the Scottish interpretation of the law aligns more closely with our stated aim of developing a learning culture and moving away from a culture of blame.’
The professional regulatory process

Question 47. What is your experience of the GMC’s fitness to practise processes in cases where a doctor has been convicted of a serious criminal offence?

There was a total of 461 online responses to this question, 356 of those responses were from medical professionals. 22 responses were from professional representative/membership organisation, college or trade union and eight were from patients or patient families.

This question yielded some factual responses describing the exposure to the GMC’s fitness to practise processes they have personally had and the capacity in which they had the experience. Others explained more about their opinions about how the processes worked and the impact that it had. 17 respondents simply said they have ‘nil’ experience.

Patient or family member of a patient

Four respondents say they have no experience.

Two don’t say whether they have experience but provide opinion. One that the ‘GMC needs to employ more doctors to gain balanced view’, the other that ‘When this has occurred it is always tip of the iceberg’. Another simply states, ‘better regulation and investigating tools need to be made available,’ however they do not provide any further comment on what tools they have in mind.

One family member tells us about their experience six years ago when their family member died. They say that they lodged their complaint about the misuse of the Liverpool care pathway to the authorities. They go on to say that, ‘the institutions whose duty it is to keep the public safe from rogue practice, namely the trust board, the GMC, the NMC and the Crown Office of the Procurator Fiscal, all closed ranks in an attempt to pervert the course of justice.’ They say that they cannot be trusted to conduct a thorough, transparent and independent investigation and that they have an institutional vested interest in preventing this. This respondent then describes in great detail their ‘lonely fight against the closing of ranks and the corruptions’ of the institutions. They say that the GMC’s expert ‘admitted that they had little knowledge and experience in the area’ and on reliance of their advice (that the treating doctor’s conduct was above the standard expected) the GMC closed the case with no further action. Commenting on this, the respondent says, ‘the unacceptable becomes acceptable to the GMC when defending their own.’ And that by, ‘closing ranks to protect the reputation of the medical profession, the GMC has damaged its own reputation beyond repair.’ After quoting an article in the Spectator on 18 October 2014, ‘Meet the bloated, useless General Medical Council,’ (the GMC has a ‘seemingly insatiable yearning for power’) they conclude their reference to the GMC by saying that the ‘bloated and corrupt’ GMC cannot assist the police with difficult investigations in the hospital setting.

One family member left a comment in response to another question about use of medical experts in coronial proceedings but it is perhaps more relevant here as it relates to a GMC instructed expert ‘...PHSO experts in first enquiry a nurse. GMC expert a retired GP to comment on ICU withdrawal of ventilator brain stem tests Come on embarrassing! With my
first submission of complaint which I really didn’t have a clue it was such a complex affair to fill out on line. GMC fortunately have put it back on a better footing.’

**First-hand experience**

A few medical professional respondents (8 online and 2 offline) cite personal (negative) experience of being reported to, or investigated by, the GMC.

**Investigation not timely, plus lack of communication and updates**

One medical professional says that they were investigated for GNM, the CPS found no grounds to pursue charges. It took 12 months to conclude the investigation and they only heard from GMC at beginning and conclusion of the investigation. It was not timely which added to the emotional burden.

**Restrictions on practise during investigations**

Another medical professional shares their experience saying that ‘...in the manslaughter process [there is] an interim-orders-panel (IOP). Here there is an opportunity to reflect directly to the GMC on the charge laid. This occurs within 3 months of the start and is there to protect patients from doctors who are perhaps still working and the GMC must decide if they should be allowed to continue. However in the other direction it doesn’t work. So the doctor being kept out of work by his/her medical director can be given the all clear by the GMC, even endorsed as having not committed any action seen as causing future patient harm, and the doctor continues to be barred from the workplace by the medical director. How can this be?’

**Other issues with the process from first-hand experience of fitness to practise processes**

Other comments include:

- ‘I found this process very threatening and stressful and made me feel guilty until proven innocent. I was charged with a road traffic offence and my mental health was in jeopardy for some 6 months due to the FTP proceedings which dragged out afterwards.’
- ‘Whilst applauding anything to protect patients the GMC leaves doctors being investigated feeling isolated and vulnerable. I know from personal experience of a minor complaint against me which was eventually thrown out, god help doctors in more serious cases.’
- ‘[The GMC] drove me crazy, concealed truth, lied in open court, failed to remove notice about hearing and destroyed family life. GMC committed more crime - responsible for the death of thousands of doctors... nothing like this in any other country, destroyed profession, discriminated against doctors.’
- ‘An anonymous accusation reported to GMC was completely fabricated so easy to refute...very stressful...couldn’t sleep...panic attacks...had to take medication...didn’t get past initial investigation’
- ‘[I was] referred once, cleared quickly [there was] still an impact waiting for clearance even when you know there is no case...as white male process was efficient and appropriate.’
- ‘No action was taken by the fitness to practice panel, but a warning letter was received indicating that if I came to attention of GMC within the subsequent 5 years they would consider revisiting their decision. Therefore despite acquittal in under an hour, the GMC effectively had me on parole for 5 years.’

Another had a ‘minor complaint from [a] vexatious patient’ and were, ‘not impressed with GMC’.
One medical professional told us that as a chair of a national committee they reported doctors to the GMC for deficient ethical standards in research. They claim that the GMC’s response was to investigate them for disparagement, which they say was ‘ludicrous’ and that the case was dropped against them. They went on to describe the handling of the complaints they had made about the other doctors. They write that the GMC allowed two of the doctors under investigation to voluntarily remove themselves from the medical register as a result of an ‘administrative error.’ The outcome of the other senior doctor’s cases was for the GMC to issue them with advice ‘only.’ They say that the GMC did not investigate the main complaint because data evidence was withheld by another body and the GMC did not use its statutory powers to compel that body to disclose it. This doctor also tells us about another time when they were reported to the GMC following the death of a palliative care patient. They say that in this complaint to the GMC they were accused of being an accomplice to the alleged murder of this patient by poison. This was after a family member of the patient had reported the alleged murder to the police, firstly accusing two nurses and then subsequently two junior doctors (as well as publishing the allegations on a website). Both of which were closed by the police with no further action. The coroner also made a finding of natural cause of death. However, they tell us that the GMC’s investigation still took two years despite these clear findings, highlighting the detrimental impact this had on the junior doctors’ ability to apply for jobs.

This medical professional also told us that they have reported ‘more than 25 doctors’ to the GMC for: ‘misconduct in research, for embezzling money from medical charities/research funds, defrauding patients and medical insurance companies and for doing unnecessary or inappropriate surgery on private patients for personal gain.’ This doctor expressed their surprise that the GMC and later the MPTS imposed lesser sanctions on these doctors referred than Dr Bawa Garba. They believe that the GMC should concentrate on sanctioning doctors for dishonesty and claim that ‘the GMC fails to put all of the potential charges and call patients as witnesses, even when they wish to give evidence.’ They go further to say that ‘the GMC and other regulators make allowances for dishonesty or even cover it up.’ This medical professional also told us that they tried to refer themselves to the GMC to ask them to investigate them for ‘poor patient outcomes and some patient deaths’ which they feel their errors are likely to have contributed to. However the GMC ‘has refused to.’

**Other first-hand experience**

15 respondents reported being directly involved in the GMC fitness to practise process in another capacity.

**Investigations not timely and are stressful**

Five of these provided evidence either in the form or reports or testimony.’ One reported another doctor to the GMC for writing herself a large prescription for painkillers, resulting in the doctor working under supervision for a year. The other 10 had roles as performance assessors, medical panellists and case examiners. One says that they ‘sat on FTP for 10 years in the past...general approach is to never go behind criminal conviction even where likely that the jury didn’t understand their decision.’ Another says ‘I have sat as a MPTS Tribunal Medical Member assessing a case where a doctor was convicted of GNM followed
by the conviction being quashed by the Court of Appeal.’ One of these acted as witness for the GMC and commented that the process was ‘too long’, it ‘covers ground already covered in criminal case’ and was ‘stressful for all concerned.’

**Second hand experience**

14 respondents have second-hand experience where either a colleague or a junior was investigated.

**‘Double jeopardy’ of criminal and professional regulatory investigations**

One respondent highlights the perceived double jeopardy of having both criminal and professional regulatory investigation and sanctions, in particular in cases in which doctors have convictions relating to their alcohol and/or drug dependency, saying that they ‘…have supported doctors who have been convicted of drink-driving, and also of possession of opiates… the doctors concerned have felt doubly criminalised by the GMC, rather than supported as sick doctors. I think this reflects a duality in thinking by the GMC between physical and mental illness.’ Conversely, another medical professional says that ‘…Drugs are always treated as a mental health condition, this isn't always fair. Stealing ketamine from work is still theft.’

**Other issues with GMC fitness to practise processes: unfair, not timely, ineffective, not transparent etc**

A few of these responses highlighted their perception that their colleagues who were referred to the GMC (one purportedly 3 times) were treated ‘abominably’, ‘wholly unfairly’ as though they were ‘guilty until proven innocent’, with ‘years of good practice ignored’, and/or they ‘felt lonely.’ One says the process is a ‘tick box exercise that doesn’t balance or evaluate evidence… Incompetent doctors lead investigations outside of area of expertise’

Another claims that the ‘…first finding [of the GMC/MPTS was] fair but further suspension due to admin error and appear was not fair or transparent.’ Similarly, another medical professional says that they had experience of employing a locum that had just been removed from the list of registered medical practitioners. They claim that the online register was not updated for more than 6 weeks after the removal of this doctor’s name and the GMC ‘didn’t even ask for the paper certificate back’. They add that initially the staff at the GMC were helpful ‘…until it became obvious where blame lay: they then refused to engage and stopped answering both emails and telephone calls. They would not even give reasons for sanction, even though these were clearly needed in deciding whether any patient populations or sub-groups were at enhanced risk from the doctor.’

A number of respondents comment on the length of investigations (ie too long) with one saying they have ‘…experience of someone facing a fitness to practise panel where there was an allegation (non clinical) that was never taken on by the Procurator Fiscal but the Healthboard investigation and FTP process have made almost no progress after 18 months. That is devastating to the Dr concerned but more widely has led to an impact on the department where they work (due to staffing gap and loss of psychological safety of staff). There is unlikely to be any resolution for at least another 12 months.’
Appropriate sanction

Unlike some respondents citing second hand experience where they thought the GMC’s handling or outcomes were inappropriate, one medical professional says they ‘...have only one experience of this directly where a doctor in my Designated Body was convicted of a serious offence he was struck off appropriately.’

Dealt with as conviction cases

One member of the legal profession says that ‘The MPTS will often (but not always) erase the doctor concerned [in cases of serious convictions]. These cases are almost always prosecuted by the GMC as conviction cases removing the need to call other evidence or examine the issues more intricately’.

No personal experience

The majority of doctors that responded to this question cited no personal experience but provided comment on the following themes (largely negative):

The GMC’s decision to appeal the MPTS determination in the case of Dr Bawa-Garba, overrepresentation of BME doctors and suicide rates

Some referred to the GMC’s decision to appeal the MPTS decision in the case of Dr Bawa-Garba (‘Bawa’ – 44 times). Others highlighted the overrepresentation of BME doctors in GMC fitness to practise processes (‘BME’ – 13 times) and doctors who have committed suicide who were being investigated by the GMC (‘suicide’ – 11 times).

Perceptions about timeliness of investigations and impact on doctor and their families

Much like the responses from respondents drawing on their second hand experience, some respondents stated that the GMC fitness to practise process is excessively drawn out, stressful (12 times) and slow moving. They say that they leave the doctor poorly supported and them and their families in ‘limbo.’

As above there were several more medical professional respondents who note that the GMC fitness to practise process effectively leads to ‘double jeopardy’ and that doctors are ‘guilty until proven innocent.’ Several stated that the approach was a forgone conclusion ‘Dr usually suspended or erased’ before found guilty.

The Royal College of Anaesthetists say they have, ‘been concerned for some time about the stress that doctors experience from investigations and the risk of litigation that have increased in recent years for the medical profession. Doctors and health care professionals experience considerably higher level of work related stress than the general working population. Anaesthetists and critical care practitioners in particular suffer from high emotional exhaustion due to the level of responsibility and ‘life and death’ decision-making expected of them. This is often exacerbated by long shifts, sometimes worked in isolation from other colleagues. Doctors in training are at particular risk from increased stress and even burnout as, depending on the stage in their training, they may lack the skills and experience necessary to deal with the after effects of stressful situations and untoward
events. This can lead to feelings of exclusion and low self-esteem. The Association of Anaesthetists of Great Britain and Ireland has set up a working party to look at suicide amongst anaesthetists. The group should report later on in the year and we would encourage the GMC to consider the findings as part of its own review into suicide.’

The Royal College of Obstetrics and Gynaecology (RCOG) also recognises ‘...the adverse impact and personal cost of all levels of investigations on individuals and has been working with members to better understand this impact.’ RCOG highlights research by Tom Bourne and colleagues, ‘...in a seminal study of nearly 8000 doctors involved in investigations that may or may not have involved criminal offences, reports high rates of psychological morbidity in doctors facing all types of complaints. Unsurprisingly, the impact was greatest on those undergoing GMC investigation.

Bourne and his team also examined how doctors changed their clinical practice in response to complaints. Over 80% of doctors reported changing the way they treat patients after complaints against themselves or others. The most common changes were “hedging” behaviours, such as over-investigation, over-referral, and over-prescribing. Just under half of doctors described avoiding high-risk patients and procedures, 23% reported suggesting invasive procedures against their professional judgement, and 16% reported abandoning procedures early. This undermines the use of professional judgement and demonstrates the worry and lack of confidence that professionals experience when dealing with fitness to practise investigations.

The RCOG understands that referrals to the GMC are high, and that the GMC has a legal duty to investigate. Reasons for high referrals are not always well understood and the RCOG believes that many incidents could be better dealt with at a local level to avoid escalation.

The RCOG has developed five principles for good complaints management and learning. The RCOG suggests that these principles have application to the work of both the services regulator, CQC, and the professional regulator, GMC, as investigations are often as much a service quality issue as a regulatory issue. The principles aim to clarify the standards of complaints management and motivate greater resolution, learning and leadership to take place locally.’

GMC appeals of MPTS decisions and seeking erasure in GNM cases

The Doctors’ Association UK (DAUK) is ‘...seriously concerned about the actions of the GMC in recent years. Of note is the recent case of Dr Bawa-Garba...We are concerned that the GMC felt that it is reasonable to appeal against the decision of the MPTS. The profession needs to have confidence in the MPTS and that the decision of the tribunal is final. The right of appeal in these circumstances seriously damages the reputation of the GMC in the eyes of doctors. It is seen by many to have transformed into a regulator obsessed with the punishment and pursuance of doctors under the veil of protecting patients... true patient safety advances will come by engendering an open, just culture where the focus is firmly on learning from errors.’
Individual medical professionals also highlight that they don’t think it is appropriate or fair for the decision to appeal to be made by a single individual at the GMC (ie the registrar).

DAUK then goes on to argue against a widely misreported element of the GMC’s policy in relation to cases of GNM saying that ‘…The GMC has claimed that a conviction of gross negligence manslaughter should lead to automatic erasure from the medical register.’ To note: The GMC has never claimed that the proposed list of offences which could lead to a ‘presumption of erasure’ [which could be rebutted] (if Parliament decided to introduce such a measure - it currently does not exist), would ever include GNM.

DAUK say they ‘...feel that this is completely unwarranted. The recent case of David Sellu is a good example of how an unsafe conviction would lead to unwarranted erasure from the register. A tribunal needs to consider all elements of a case, be able to consider in human factors and weigh up the interests of the public versus the interests of the doctor. It is fitting that this takes place at a tribunal and that a GNM conviction does not signal automatic erasure.’

The BMA are also concerned, about ‘...the implications of the recent judgement of the High Court in the case of Dr Bawa-Garba and also oppose any presumption that a conviction for gross negligence manslaughter should lead to erasure save in exceptional circumstances.’

The Medical and Dental Defence Union of Scotland is also ‘...extremely concerned by the recent direction of travel pursued by the GMC which seems to suggest that in certain specific cases (including GNM), erasure can be the only available outcome for a doctor. Such an approach effectively fetters the discretion of the MPT to consider, as it is expected to do, all aggravating and mitigating circumstances which will include: surrounding circumstances; evidence of a doctor’s good standing and clinical ability; and evidence of insight and remediation.’

The BMA adds that it has ‘...consistently opposed and remains deeply concerned about the right of the GMC to appeal against fitness to practise decisions... this right risks undermining doctors’ confidence in the independence and fairness of the MPTS. Fitness to practise processes are very stressful for doctors and the perception of a risk of double jeopardy can only exacerbate this problem.’

The MDU say that the GMC’s FTP process [in cases of serious criminal convictions] ‘...doesn’t differ in that all cases that are determined to meet the threshold are investigated in the same manner. There are some practical differences that are outside the GMC’s control, for example with timescales for GNM cases, as the GMC usually waits until there is a decision from the police or, if the case is prosecuted, until there is a court decision. The GMC may also have difficulty obtaining evidence from the police.’

**Interim order suspension during investigation**

MDU say that the main problem ‘...is that interim orders are very frequently applied when doctors are investigated for GNM. Very often in these cases, where the investigation can last a year or more, the doctor become deskilled, not to mention the stigma attached and almost invariable loss of confidence. This is particularly frustrating in cases where the trust would have allowed the doctor to continue to work, even if in a different or non-clinical
role, save for the interim order...referral to an interim orders tribunal should [not] be used so readily when the GMC knows that the great majority of GNM investigations are discontinued and that, ultimately there are no regulatory findings or sanctions. There is...an inappropriate concern on the part of the GMC and MPTS interim orders tribunals that the mere fact of a police investigation means that public confidence in the profession can only be maintained by making some form of interim order...the public is more intelligent than that.’ They also add that some trusts are supportive of a doctor and keen for them to continue to work, if not in the same job, elsewhere in the trust using clinical skills, or in a clinical role. But of course, they cannot do that if the doctor has a GMC interim order suspension.

Looking at cases where doctors have been suspended as a result of their involvement in GNM investigations which then came to nought, is it not possible for regulators to identify factors that could indicate a different and more proportionate approach? The GMC has acknowledged in the last few years that most single clinical incidents are unlikely to amount to impaired fitness to practise and such cases are now generally referred to its provisional enquiry procedure. We believe it should look at GNM cases, which are invariably single clinical incidents, in a similar way. We are not suggesting they should be preliminary enquiries, but that the GMC should satisfy itself that the approach it takes to referral for interim orders of such cases is consistently proportionate and fair.

The Royal College of Physicians Edinburgh call for ‘...a much clearer understanding of the impact of a clinical conviction. Are all doctors with a criminal conviction removed from the register? When the regulator makes a decision on registration, what factors are taken into consideration – the conviction, the issues and events surrounding the circumstances of conviction? Peer/senior experiences of the doctors? All of this is now essential knowledge for clinicians and must be clearly set out. The recent cases have perhaps highlighted the differing roles of the GMC and the criminal justice system and it is important that one does not try to replicate the job of the other. For the most part the sanction imposed by the GMC would be commensurate with the conviction but it is entirely reasonable that the response to an incident would differ in some circumstances. However, in one recent case it has become apparent that many consider the resulting conviction to be unreasonable and, given that, have difficulty comprehending why the regulator acted as they did.’

The Trainee Committee Honorary Secretary (of the Association of Anaesthetists GBI) advises that ‘...from a trainee’s perspective, the GMC Fitness to Practise process is poorly understood. However, notably there has been concern in light of the Dr Bawa-Garba case. There has been a particularly emotionally driven response – specifically anger and fear. Part of this may be fuelled by the lack of understanding of the process. Trainees have a poor grasp of when a complaint to the GMC becomes a matter for the Fitness to Practice tribunal. On the GMC website this is not well explained or easily found and the experience is a little limited to what has been publicised in the media.’

Opinion derived from the media/press coverage

Some respondents noted that their only knowledge came from what they had read in the press. These comments often correspond with an opinion that GMC fitness to practise
processes are swayed by public opinion including phrases like: ‘Witch hunt’, ‘media hype’ and ‘bending to the will of public whim’...‘the GMC should look at the actual potential for harm to patients from an individual rather than public/family perception of harm.’...Its role is to ensure safe practice not make examples of doctors to satisfy the mob/media.’...The GMC comes across as ‘judge, jury and executioner’. They are a muddled organisation, who appear to want to be a patient safety organisation rather than a professional regulator.’

There were a couple of respondents stated that they avoided media reporting on the subject and only looked to professional publications such as the BMJ and GMC reports, they provided no opinion about GMC fitness to practise processes.

One medical professional say they ‘...cannot understand how the GMC can be expected to second guess the criminal courts when they convict a doctor of a serious criminal offence. The doctor should be removed from the register. The GMC may review that decision if the conviction is subsequently overturned or if the act is later decriminalised.’

Another doctor touches on this area further saying, ‘There is an area of concern about what is a "serious criminal offence" since we do not have the distinction between misdemeanour and felony seen in some jurisdictions. It is probably more fitting for parliament to make that distinction than for the medical profession or GMC to decide.’

**Inconsistency in treatment and outcomes of GMC fitness to practise processes**

13 respondents stated that there are inconsistencies/differences in the ‘treatment’ or ‘punishments’ and the application of standards for the ‘same offence’, claiming that it ‘seems to be a lottery’ or ‘very variable’. One of these responses stated that this opinion was ‘based on FOI (Freedom of Information Act requested) information.’

Others ask ‘...How have doctors who have committed sexual offenses’...’doctors with convictions for stealing prescriptions for opiates or episodes of domestic violence’...’doctors that have signed livers out of arrogance’... ‘doctors who have lied’ been allowed to stay on, continue to practise or be readmitted to, the medical register, but ‘they [the GMC] are chasing down individual doctors who have fallen fowl of system errors’ or those who have made ‘genuine mistakes are struck off?’

**The GMC’s fitness to practise processes are punitive/unfair/not trusted/do not allow for proper analysis etc**

A number of respondents expressed their view that the GMC is (‘highly’) ‘punitive’/’overly paranoid’/‘obsessed with the punishment and pursuance of doctors under the veil of protecting patients’ or to ‘appear outwardly robust rather than facilitating best care’...‘lacking in objectivity on risk’, although ‘it is not supposed to be punitive’. Or they describe the fitness to practise processes as a ‘revengeful system of punishment.’ One respondent says that, ‘The GMC appears to act like the mafia. It has stated in previous cases its role is to send ‘a message.’ Another respondent goes so far as to say that ‘...the GMC is a terrifying organisation seeking to harm doctors when opportunities arise whilst being funded by doctors.’
A respondent (categorised as ‘other) says that ‘the GMC comes across to me an organisation that is filled with the power-hungry unreasonable ex-medics. It is not seen as fit for purpose and is consequently not trusted.’ Another respondent (a representative of a voluntary organisation/charity) has given evidence at a GMC hearing and says that it is ‘daunting whether you are for the doctor or giving evidence against.’

Broadcaster Nick Ross describes the GMC’s fitness to practise processes as ‘...unfair, expensive, distracting, drawn out’, and a ‘disincentive to remain in profession’. He suggests the review gets data rather than ‘just anecdotal responses.’

One respondent says that fitness to practise is ‘...managed by caseworkers who do not have sufficient skills or technical knowledge to make good decisions about case management frequently, distressing for the doctor (to the point of serious mental/physical illness/suicidal), and having a deeply damaging impact on their career.’

Dr Jenny Vaughan says that the GMC ‘seem to have a fundamental misunderstanding of what actually goes on in a medical GNM conviction and how the adversarial process does not allow a proper analysis of the facts.’

**Bias against BME doctors**

There were some mentions of a ‘hostile environment against minorities/BME doctors’ and that the GMC are ‘enforcing this perception’ of minority doctors (although did not elaborate on what ‘this’ is), or that there, ‘seems to be bias, erasing BME doctors or at least furthering their investigations more often that Caucasians.’

**Other perceptions**

There were a number of other comments made that do not neatly align RELATE to the themes identified above:

- ‘Should be replaced by specialty led FTP panels...GMC has become political organisation not relevant to practice of medicine...used as a threat to silence potential whistle blowers’
- ‘GMC should only be involved in cases that include clinical care / not moral police’
- ‘Largely fair but occasionally have protective bias ie act to protect own reputation or that of a doctor’
- ‘GMC can’t truly protect patients as it has no authority of NHS funding.’
- Royal College of Psychiatrists Scotland argue that ‘Fitness to practice reviews should be held in Scotland for Scottish–domiciled doctors, and follow Scottish rules of evidence.’ They go on to say ‘A distinction must be made between criminal prosecution occurring through gross carelessness in a doctor’s clinical practice, and criminal acts occurring outside of a doctor’s clinical practice which have implications for their professional practice.’

The Law Society Scotland advise that ‘...As recognised in the Fatal Accident Inquiry into the death of Norma Haq, there is an inevitable overlap in the evidence which will be heard in any criminal case and/or FAI and/or any future disciplinary proceedings:

The separate roles of the various organisations should be respected. The findings of guilt or otherwise in criminal proceedings or findings in any determination are quite separate, cannot and should not be relied on to any disciplinary proceedings which fall to be taken or indeed, considered in line with the GMC regulatory procedures. The Scottish system allows
for a wide independent process for full investigation to take place. That is before any decision as to any proceedings, criminal or otherwise takes place. With the safeguard of judicial review, this approach works.’

**The GMC ‘takes appropriate action’**

Unlike the majority of negative perceptions/experiences shared about the GMC’s fitness to practise processes, there were a few comments that demonstrated some moderately higher levels of trust in the GMC’s effectiveness:

- ‘They seem to take a balanced view and come out with a sensible conclusion based on facts available both regarding the actions of the doctor and also the system pressure they were working under. They take into account all of the working practices of the doctor and decide if they are safe or not to continue. It seems a sensible practice which should be the main decider as to the fate of the doctor’
- ‘Have relied on it for a century and it seems to have been reasonable’
- ‘Good experience working with GMC as past MD/RO of Trust…GMC v positive in terms of trying to offer support in medical / substance abuse. Recent case appears poor behaviour by GMC - popularism - at face value failed in their duty’

The Professional Standards Authority say that in their experience, ‘the GMC takes appropriate action when doctors have been convicted of serious criminal offences. There have been occasions where we have disagreed with the findings of a panel or with the GMC’s decision to appeal but we have no concerns about the general approach by the GMC.’

One respondent (categorised as ‘other) doesn’t say how they have experience of fitness to practise processes proves but that ‘GMC processes are generally very thorough and fair, holding people to account and observing very high standards of professional behaviour and justice.’

Another respondent leaves the following feedback about the MPTS hearing centre in Manchester ‘...staff very kind and caring. Went out of their way to help my trainee relax...Whole process takes far too long to get to the hearing stage...unbelievably stressful- see suicide data.’
Question 48. The GMC has a statutory duty to: promote and maintain public confidence in the medical profession, and promote and maintain proper professional standards and conduct for doctors. What factors do you think the GMC should balance when trying to fulfil both these duties where there have been mistakes that are ‘truly, exceptionally bad’ or behaviour/rule violations resulting in serious harm or death?

There were 494 responses to this question online. Medical professionals gave 430 of those responses, 21 were from a professional representative organisation, college or trade union, and 14 responses were from a patient or family member. There were mixed views in responses to this question. For example, some respondents felt that the duties of the GMC to ‘promote and maintain public confidence in the medical profession’ and ‘to promote and maintain proper professional standards and conduct for doctors,’ are incompatible, whilst others felt they were linked (one achieves the other) or are complimentary duties.

The Professional Standards Authority advise that it is ‘made clear by the case law, the limbs of public protection are not intended as a hierarchy but are all equally important elements of ensuring public protection which must all be considered when deciding on the appropriate sanction...further work is required to better understand how public confidence can be affected and to help to inform and bring greater consistency to decisions made by regulators, fitness to practise panels, the courts and the Authority about appropriate fitness to practise outcomes.’

The Nursing and Midwifery Council submit that ‘...Rather than seeing it as balancing act between various competing duties we think there is a real need to reframe the issues which lie at the heart of this question. Namely, in a learning culture what role does the regulator play in answering questions about what went wrong and then managing what comes out of it?’

Some respondents, particularly medical professionals, who reported their view that the GMC has misinterpreted/confused or ‘adopted an approach which places excessive emphasis on’ its duty to ‘promote and maintain public confidence in the medical profession’ or otherwise shared views/criticisms about the GMC more generally.

The GMC tell us that they ‘set out the factors for decision makers to consider when determining what action to take when a doctor has put patients at risk or undermined confidence in the profession in our Sanctions guidance. The guidance is based on the values and standards contained in our core guidance, Good medical practice and seeks to ensure that decision making is fair, proportionate and consistent.’

To the contrary some respondents highlighted the views that:

- ‘Maintenance of public confidence is not the same as being seen to punish someone’ (Academic)
- ‘press [coverage] shouldn’t be a measure of public confidence’
- ‘the GMC seem fixated on how they are perceived in the press and use that measure to justify a measure on public confidence rather than applying judgement or common sense.’
- ‘The GMC must remember patients in the round, not just the one whose family sits before them.’
- ‘Patient safety [is] most important...Consider this before [the] need to punish individuals.’
Similarly one patient or family member respondent argues that the ‘...GMC should maintain standards, not vilify [doctors?]’ The respondent goes on to say that the ‘GMC should err towards education, support and improvement, the Police should pursue if they feel a case can be brought.’

They add that the ‘...GMC should judge FTP [fitness to practise] on the case not public outcry’ and say that it [the decision?] should be ‘in the hands of the MPTS as the GMC are too motivated by public opinion or pleasing other parties such as the Government or media’. They criticise that the GMC treat ‘...sanctions as only way to keep public confidence’ and say the GMC ‘...should not allow their faulty perception of public confidence to trump natural justice and individual rights.’

Similarly, the Royal College of Psychiatrists Scotland argue that ‘...The GMC as a regulator and impartial review body may be open to criticism from the public where a criminal prosecution does not occur, though wider criticism does not mean its decisions are inappropriate.’

The Intensive Care Society warn ‘there are serious dangers in trying to react directly to ‘public confidence’ as an outcome in itself, most particularly over single cases, as this is very vulnerable to short-term manipulation (intentionally or not) or disproportionate amplification through media...This makes it impossible to guard against bias brought about by differential public responses based on extraneous factors ranging from how a story is presented, through to the ethnicity or other characteristics of the defendant... It may of course be appropriate for the GMC to monitor public perception in order to ensure it is delivering its objective, but some form of ongoing, regularly sampled metric and trend would be a much safer method than considerations of how individual cases are perceived as they are happening. It should also go without saying, that there should be no conflation between ‘maintain[ing] public confidence in the medical profession’ and maintaining the reputation of the GMC itself.’

Medical Dental Defence Union of Scotland ‘...fully appreciates that the reputation of the wider profession is more important than the interests of any one doctor; but the GMC seems to have taken this to an extreme without recognising the significant damage done to the morale of, and confidence within, the wider profession by the GMC’s approach in individual cases. It cannot be in the public interest to create a culture of defensive medicine; and it certainly cannot be in the public interest to discourage doctors so that they no longer wish to work in the profession. It is crucial that the profession should feel able to have confidence in its regulator.’ This concern about the profession’s confidence in its regulator is also shared by a number of other respondents.

NHS Education Scotland add that ‘...the public clearly and properly need protection from the bad behaviour of doctors... It is noteworthy that at present, the public feel that the GMC is on the side of doctors and doctors feel the exact opposite, describing an approach that is often characterized in conversation as ‘guilty until proven innocent.’’ Similarly the Royal College of Obstetrics and Gynaecology (RCOG) highlight the ‘perception within the medical profession that the regulator is too heavily on the side of patients, often to the detriment of the profession.’
This contrasting perception of the GMC between the public and the profession was also demonstrated in a few responses from patient or family members:

- ‘If a Doctor is in breach of their statutory duties they take the consequences. The GMC is too lenient and has blood on its hands.’
- ‘The GMC need to act mainly on the side of the public.’
- ‘The GMC close ranks and ‘protect their own’
- ‘The first balance should be to the families of the harmed and dead. I have been told re my case 'great learning' has taken place but these words do not satisfy me I have no way of checking that further harm and death will not occur.’
- ‘I think the GMC themselves are confused. I have experience of doctors whose behaviour is really bad being allowed to stay on register and those related to fatality suspended for a few months only.’ (Voluntary organisation / charity)

However a couple patient and family member responses were either more neutral or reflected similar views to those held by the profession, for example:

- ‘The GMC should be fair and unbiased.’
- ‘The system or environment in which the doctor operates is key. The GMC should reserve their input against individual doctors where they have individually done something which is seriously untoward.’
- ‘Has the doctor shown enough learning and insight into his/her own actions to reduce the future risk they pose to patients.’
- ‘I think each case should be judged on the facts and not by some agenda to prove the GMC are a ‘harsh’ regulator and therefore worthy of the public trust and doctor's money to pay for their regulation.’

There were a number of individuals and organisations that call for research into what affects public confidence in the profession. The BMA and the Doctors' Association UK share the view that ‘...the concept of public confidence is poorly defined by the GMC.’ The BMA call for guidance following research into the question of what members of the public would really expect in cases involving clinical error, and DAUK say ‘...The regulator claims to promote and maintain public confidence in the profession but fails to objectively state how it will do that. Public confidence is more subjective when considered in detail...We would hope that the GMC opens an independent workstream to fully consider public confidence in a number of cases, this should therefore inform the decision making and conduct of both the regulator and the MPTS.’ The Royal College of Anaesthetists also highlight that the ‘...Williams Review reports states, greater clarity is required on what ‘public confidence’ means and what exactly is the role of the GMC in protecting it, given that the Professional Standards Authority has the same statutory duty and legal powers around this. It would be appropriate to ask the public via independently commissioned focus groups or surveys on their views of what sort of scenarios would erode their confidence in the medical profession.’

Muslim Doctors Association advises that ‘...The GMC takes steps to ensure impartiality of its decisions; through scrutinising, for example, the extent of influence of wider political and other non-medical agendas driving public sentiment and perception on its decisions. Our own survey of over 300 doctors demonstrated that 43% felt that racial discrimination was a driving factor for the public in applying pressure on the GMC. Scrutiny of such influences on GMC decisions is best achieved through external and internal auditing.’
A number of respondents believe that ‘...maintaining public confidence can include explaining how honest hard working doctors are supported to learn from mistakes.’ One respondent queries the effectiveness of sanctions on a doctor’s practice, saying ‘...There must be statistics on further issues for doctors suspended when they return to practice. Are they more or less likely to be involved in further incidents?’

Similarly other respondents believe the GMC:

- ‘must take part in the education of the public about doctors mistakes and the significant contribution that under resourcing plays in this so that the public confidence in the medical profession is maintained even if this is at the expense of confidence in the NHS overall. They must be more active in demanding resources so that doctors can maintain the standards they set. Eg patient involvement in decisions about them and proper consent are impossible without adequate time.’
- ‘should be campaigning for resources and staff.’
- ‘unless it confronts the tory govt- does nothing to promote professional standards. You cannot have professional standards when work is crisis management.’

Other respondents add that:

- ‘While clearly the GMC has a duty to patients, part of that duty is to ensure that the medical profession is empowered practice and not be worried as then more mistakes will be made’
- ‘perhaps there should be some emphasis on the idea of promoting confidence in a positive way rather than but publicly slamming doctors who make mistakes...Perhaps by highlighting and publicising good practice and care?’
- ‘Realise that these cases are far less common than anyone realises and publicise this.’

Some went as far as to say that ‘...It should not be a regulatory function to maintain public confidence, this will only lead to judgements based on factors such as personal characteristics of the 'victim' and 'perpetrator'. One respondent says ‘...The GMC is not this [i.e. promoting and maintaining public confidence in the profession] and should devolve its powers to the royal colleges that clearly do.’ Another says that the GMC has ‘...conflicting roles - these should be separated and funded appropriately.’

Similarly, other respondents argue that ‘the GMC's sole concern should be whether a doctor is morally and technically competent to be on the register”...the GMC should drop their statutory duty to consider public confidence in the profession. It is an arbitrary, immeasurable and the cause of many wrong decisions, going back to Profs Meadow and Southall, and their torment of Dr Al-Zayyat in the Baby Peter case... A focus on patient safety would be altogether more meaningful.’

Some argue that ‘...The public only want punishment of the highest order now and will not be content with anything less than destroying a doctors reputation and livelihood. All GMC cases should remain anonymous because of this until blame has been confirmed.’

A respondent suggests that ‘...An independent investigating body would help to inform the regulator regarding events and improve confidence of the public and the profession that the GMC has acted in an even-handed manner.’ Another respondent advises that ‘...in any case, a duty imposed by statute is not a duty that needs to be pursued officiously. There is a huge spectrum of options available to the GMC - from never erasing someone making exceptionally bad mistakes to always doing so.’
Conversely, there were a number of respondents who ‘don’t see that there is a tension between the two’ and thought that the ‘GMC should focus on standards and conduct / promoting and maintaining public confidence is a by-product of these’ or ‘falls into place.’ Intensive Care Society believe ‘...the balance should be very heavily weighted toward maintaining proper professional standards and conduct as a primary objective, with the maintenance of public confidence being the successful secondary outcome of the former if it is conducted reliably.’

In relation to the duty to promote and maintain high professional standards, one medical professional shares their view that ‘...The GMC has to uphold the highest possible standards. I have never heard any doctor complain about the decisions that the GMC comes to as a result of its investigations’

Factors the GMC should balance when trying to fulfil both these duties where there have been mistakes that are ‘truly, exceptionally bad’ or behaviour/rule violations resulting in serious harm or death

There were a number of factors that respondents advised should be considered, which included:

i. What is ‘truly exceptionally bad’ and how should it be assessed?
ii. Interaction with the law of GNM and intent/the doctor’s state of mind
iii. Mitigating (system) factors
iv. Doctors past performance/record and likelihood of recurrence
v. Motivation of the complainant
vi. Relevant medical expert opinion
vii. Impact of removing the doctor from practice

Further detail on these commonly identified factors is covered below:

i. What is ‘truly exceptionally bad’ and how should it be assessed?

There were some respondents who highlighted the GMC’s appeal of the MPTS’ decision to suspend Dr Bawa-Garba, how they believed that GMC wrongly perceived that the MPTS ‘went behind the jury’s verdict’ and how they believe that ‘a one off error shouldn’t result in erasure,’ as there is ‘no suggestion that permanent erasure helps maintain public confidence per se.’ They say that the jury was not asked to determine facts in that case, they are of the view that the jury gave an ‘opinion’ on whether the conduct was truly exceptionally bad but the MPTS should be allowed to look at all the ‘facts’. One patient or family member says that the ‘GMC should leave it to the MPTS to decide.’ A medical professional advises ‘...Don't relinquish responsibilities by accepting flawed criminal proceedings as gospel.’ It is worth noting (again here) that the Court of Appeal decision to overturn the high court decision was not laid down before the close of this questionnaire.

The Association of Surgeons in Training believes that ‘...erasure of a doctor from the medical register solely to promote and maintain public confidence in the medical professional is unacceptable.’ Respondents advise that the GMC should have greater regard to the full range of sanctions at its disposal. The RCOG believes that increasing the transparency of the GMC’s processes and rationale would help rebuild the trust and confidence of the profession in the regulator.
The Professional Standards Authority advise that ‘...the role of a professional disciplinary tribunal is different to that of a court. Whilst a criminal conviction for gross negligence manslaughter must be recognised appropriately by the tribunal, the panel is required to consider a wider range of issues in coming to a decision on sanction. These issues include the insight that is displayed by the registrant and the extent to which they have remediated the failings which were the basis of the offence of which they were convicted. These will vary according to the individual facts of the case. It is therefore for a professional disciplinary tribunal to consider the specific facts of a case and how best the three limbs of public protection can be satisfied based on the individual factors. We would oppose any automatic sanction in such cases.’

Respondents query more widely in their responses ‘...who decides if the mistakes are truly exceptionally bad? Is it a body of peers with the same training and experience, or is Jo Public?’ They claim that ‘...with hindsight many things might look truly exceptionally bad but at the time they made sense to the person.’ A medical student comments that ‘...There is a difference between a mistake and a behavioural or rule violation. Human/individuals make mistakes. There may be systems in place to mitigate against these, but these are rarely fool proof (never events are not never events or the phrase would not exist). This is different to a doctor who is unable to demonstrate competencies to fulfil their role, for whatever reason.’

Some respondents suggest that a good test of this is ‘...what would average person with that experience would do’ another argues that the GMC ‘should be considering polling other doctors in the same situation to gather their opinion. A randomly selected medical jury would be an idea, not to decide unanimously but to give their independent view.’

Others highlight the importance of medical expertise in this, saying for example, ‘...truly exceptionally bad is a useless statement unless it comes from supervising doctor, close colleague or group of medical people. GMC have duty to appoint qualified people regardless of media and courts (which are not medical).’ Similarly another medical professional thinks that ‘...truly, exceptionally bad errors should result in professional consequences which may include restriction to practice or removal of privileges altogether. The family’s role is to highlight and provide evidence. A decision about the quality of the doctor’s practice should be made by clinicians.’

‘The GMC needs to be prepared to provide an opinion as the regulator in individual cases of whether or not an act is a mistake (as opposed to a difference of clinical opinion) and if the mistake is "truly, exceptionally, bad" they do after all have a huge repository of investigations to judge by.’

One respondent left the comment that ‘...The GMC should stick to clinical cases and let the police deal with criminal offences like the public.’ Although didn’t expand on what they meant by ‘like the public.’

ii. Interaction with the law of GNM and intent/the doctor’s state of mind
Much like the responses to the first two questions (on what people perceive to be criminal acts), some of the respondents said that the key issue is that there needs to be a change in
law, not that the GMC should necessarily act or balance factors differently. Some tell us that:

- it is ‘... difficult for GMC to argue court findings’
- ‘...the discretion allowed to the GMC in circumstances of proven gross negligence manslaughter seems to be greatly limited’
- ‘The authority of the law exceeds that of the regulator. Regulator should then take action based on legal decision.’
- ‘...I would fully expect to be 'struck off 'if I was convicted of a criminal charge such as negligent manslaughter. If I felt I had been subjected to a miscarriage of justice I would... appeal. The GMC can only do what it can in the face of current laws. It cannot be above the law. I don't agree with the motion to strip the GMC of its powers to remove doctors in these cases. I think the law should be changed - If you weaken the GMC then you will weaken the public confidence in our profession.’
- ‘The application of the criminal law to medical misadventure has been described as very harsh in that the individual is either guilty or not guilty of a criminal offence that directly impinges on their professional role that the GMC exists to regulate. If errors that fall short of recklessness and do not necessarily mean that the individual is irremediable in their clinical practice then the application of the criminal law would have to change rather than the standards that are applied by the GMC.’
- ‘...People make mistakes all the time. Doctors are, first and foremost, human beings who make mistakes. Very few doctors set out to harm their patients deliberately. I have not found a definition of "Truly, exceptionally bad practice" that is anything other than arbitrary. The circumstances in which an error happens should be part of any investigation and previous good practice taken into consideration.’

Respondents say that GNM in the medical setting is too focused on the outcome (i.e. death), querying ‘...does the effect of a mistake make it more worthy of punishment? Think not, though that may not sit well with public.’ Another adds ‘...Should a doctor be charged, convicted and punished according to the outcome of their mistake or behaviour? This type of thinking is applicable to criminal behaviour, for example, if a person punches someone and they die they will face a more serious charge. It is not appropriate to clinical medicine where a doctor goes to work not intending harm and trying to help.’

‘There are so many examples of good care but... negative outcomes are getting too much attention.’

Because of the perceived issues with the application of the law of GNM in the medical setting, we are told that ‘the GMC must approach clinical GNM cases very cautiously and recognise that a conviction (at present) may not in fact mean the doctor is substandard. Clinical GNM is not the same as a rape conviction or another conviction that suggests the behaviour is such that the doctor’s ongoing work will bring disrepute to the profession and / or may risk harm to the patient.’

Respondents add that ‘...the term ‘truly, exceptionally bad’ is not suitable in this context. Minor mistakes made in good faith by responsible clinicians can have 'exceptionally bad' consequences in healthcare. Intent and degree of indifference are the factors that should be considered.’ One argues that ‘...If a mistake is truly a mistake, it is not gross negligence manslaughter.’
Some respondents believe an important factor the GMC should establish is if there was 'intent to harm' and that 'honest mistakes should be recognised as different from wilful actions including eg turning up at work drunk or intoxicated.’ They feel that the ‘concept of mens rea is as important as actus reas.’ NHS Improvement advise that ‘...The GMC should refer to the ‘NHS Improvement Just Culture Guide’ in determining where action against an individual may be appropriate.’ The first test laid out in the guide is ‘the deliberate harm test’ in which readers are guided to question ‘was there any intention to cause harm?’

**Mitigating (system) factors**

Several mitigating factors were repeatedly raised as needing to be considered. We are told (in particular by the Royal College of Psychiatrists Scotland) that ‘...the interpretation of public confidence must be relative to the facts of the individual case and without any presumptions. The overall circumstances of a case must be considered, and medical tribunals should have the right to all evidence available. The context of wider system pressures must be assessed.’

A legal professional advises ‘...The GMC has to 'prosecute' all such cases but should examine independently the question of culpability in the wider context of the practice of the doctor concerned. The focus is normally upon the severity of the incident itself while the mitigating circumstances surrounding the incident, such as the doctors lack of support, are often left for the defence to bring forward.’

Another respondent advises that ‘...truly exceptionally bad mistakes are very rare - when they occur they are frequently multifactorial.’ These factors include: quality of training, experience, appropriate support, team dynamics, system pressures e.g ‘rota gaps creating a heavily increased workload or lack of rest’, environmental factors, ‘task saturation,’ infrastructure resources and management e.g. scheduled to be on-call early into new placement with no/inadequate induction. They argue that:

- Consideration of system/human factors is imperative because ‘...No amount of punishing the doctors will make a bad system good.’
- It should clearly identify lines of responsibility and where this stops/starts e.g. when is the doctor in training responsible for their actions and not the consultant supervising’ (other healthcare professional)
- ‘The way a patient presents and the way information becomes available influences a doctor’s decision making. Those looking at the incident with hindsight will receive the same information in a very different way. It is important that the GMC ensures that they don’t just look at the facts but the way events unfolded and the pressures on the doctor concerned that was beyond their control. It is important that doctors are not elevated to the position of superman/woman and expected to be unaffected by fatigue and demands on their time and attention.’
- ‘They have to assess the risk of the situation arising again for an individual doctor, and in particular should have some ability to report Hospitals where staff are being put in such a risky situation as a safety issue.’
- ‘Clearly, the GMC does need to assess the wider circumstances of a death and acknowledge that whilst one doctor maybe nominally responsible for mistakes, these mistakes are

36 [https://improvement.nhs.uk/documents/2490/NHS_0690_IC_A5_web_version.pdf](https://improvement.nhs.uk/documents/2490/NHS_0690_IC_A5_web_version.pdf)
frequently tied up with wider issues around staffing, training, support, equipment, documentation and both human / systemic factors. This is important because if the ultimate aim is to prevent the same thing happening again, penalising an individual with no reference to the environment they were working in may result in further harm to patients if the environment was a contributory factor.

- ‘The GMC should consider how well the employing organisation and the healthcare regulatory body CQC has ensured the organisational context and environment can allow a Dr to promote and maintain proper professional standards.’
- One respondent urges that ‘...The minimum standard requirements for a clinical situation must be proved optimal before considering it a mistake.’ Another advises that the review ‘...should tell the government they have to enforce all the Francis report suggestions (where are the minimum number of nurses?).’
- ‘Mistakes that are "truly exceptionally bad" should be "caught" by the system if the "truly exceptionally bad" error is not caught by the system then it is the system that is "truly exceptionally bad”’
- NHS Education Scotland add that ‘the GMC is a regulator of individual doctors, and is not by statute a regulator of the entire healthcare system. This is important - a vast body of evidence attests to the fact that when things go wrong, and a patient suffers avoidable harm, it is seldom the case that this is the consequence of the act (whether of omission or commission) of a single individual – but commonly multiple factors are in play – whether these be other individuals, or features of the wider system, for which others are responsible.
- The Royal College of physicians advise that ‘...Context is all important when deciding if someone was wilfully negligent or acted with deliberate intent to harm. An action or omission cannot be judged to be truly, exceptionally bad outside of context... The actions of a trainee doctor in a small local hospital, with a high burden of competing tasks, some of which are unfamiliar, and when suffering from fatigue, must be treated differently to the actions of a consultant in a large teaching hospital.’

The GMC tell us that they ‘...fully recognise the value of exploring a human factors approach and have met with leaders in the field of human factors to consider how we might ensure that our response to systemic issues is effective and reflects best practice.’

iii. Doctors past performance/record and likelihood of recurrence

Respondents pose the questions: ‘Has this happened before? How unprofessional was this? What does this reflect? Do they have the potential to learn from past errors and return to practice safely? Are these doctors up to date with their revalidation appraisals? Is there evidence of learning or willingness to learn from the mistake?’ One respondent provides the simple assessment - ‘Decide - did they make a terrible mistake or are they a terrible doctor?’

Association of Anaesthetists say... ‘If a criminal conviction concerns a single act and there is no evidence that it represents a pattern of poor behaviour and practice, then protection of future patients should be the main concern and the Fitness to Practice hearing should focus on whether there are on-going concerns. It is important that the GMC’s actions are not punitive.’

‘It is possible for any human being, no matter how good a doctor to make an "exceptionally bad" error. The system allows this to happen. This should be balanced against a professional’s track record... Losing one’s temper may be a once in 30 years event or a daily event.’

We are advised that the GMC should consider the possibility of ‘rehabilitation’ / potential for future harm and ‘likelihood of recurrence’ because ‘...recurrent exceptionally bad behaviour
is significant’. One respondent shares their view that ‘...usually doctors who make serious mistakes have made several smaller mistakes (as in all the 3 cases disciplined by the GMC that I was aware of personally).’

Other respondents add that ‘good regulation must be used to keep clinicians honest and ensure that they reflect on and learn from mistakes’ and say that ‘...Rehabilitation should be supervised by the GMC and royal colleges.’

One medical professional tells us that they ‘...have knowingly employed doctors who have GMC sanctions because of their honesty and learning from an incident. I am confident that they are less likely to commit a further error. So far I’ve not been disappointed.’

iv. Motivation/views of the complainant
There were a number of respondents who highlighted the litigious, blame or ‘claims culture’ and their perceptions about ‘money hungry lawyers’ and the motivations of the family members for pursuing legal redress:

‘Difference between motivation to find learning and legal money grabbing - claims culture’

‘if there are no previous complaints about a doctor, care should be taken to avoid the verbal evidence of someone who just may not like that doctor personally. The general public is protected when doctors are protected from vendettas against them.’

‘I see no value in legal representation which completely changes the nature of the process from open and based on learning from mistakes and improving practice, to winning the case with inevitable outcomes of 'vindication' for the family, 'winning' and remuneration for the lawyer, disaster for the doctor and a continuation of the slide towards defensive practice for the profession.’

v. Relevant medical expert opinion
In relation to the use of medical expert evidence, respondents provided their views that:

• ‘Of bigger concern in the Bawa Garba case was that the experts used were not doing the same job and had no experience of the pressure.’
• ‘Specialists should not give evidence with the clarity of hindsight about judgements made by non-specialists about how much they should have known at the time. Other non-specialists should do that.’

vi. Impact of removing the doctor from practice
Some respondents highlight that the following factors should be considered:

• ‘Impact on doctor retention, recruitment... impact on faith in system...pushing vulnerable doctors to suicide’, Justice and fairness to the doctor.
• ‘Awareness of the impact of the decisions on victims and their families’.
• ‘Awareness of the impact of the decisions on safe practice by other doctors.’

The BMA note that ‘the public confidence criterion permits tribunals and courts to take into account the public interest in an otherwise good and competent doctor being permitted to continue to practise.’

Other opinions

• ‘The GMC does a very good job, and should continue the good work, but always be careful to avoid bias.’
The activity that the GMC undertakes with students and doctors in training to explain and advise on Good Medical Practice is a very fair way of ensuring that our profession does understand our responsibilities. Doctors who come to the UK after foundation training might benefit from these sorts of opportunities.

NHS Scotland advise that ‘...The GMC should widen its sphere of interest to quality assure process by which an AMBER-ZONE of risk to patients is managed. The focus of the GMC should move upstream to prevent harm rather than purely manage the harm that has occurred.'

There were many respondents who called for the introduction of funding for the GMC from the ‘public purse’, for example comments such as: 'There appears to be a direct conflict, in the fact that the regulatory body is funded by doctors themselves. This self-policing clearly is failing. In a monopoly system like the NHS, the regulatory body should be funded by the public.' '...There has to be separate government paid body.'

Faculty of Pharmaceutical Medicine claim that ‘The issue is to separate the supporting and standard setting role of the GMC from its judicial role and this can be done within the single organisation through the use of a separate powers of MPTS.’

'Suggested over many years to have confidential but honest discussion of impact of racism and also bullying culture on NHS and patient safety but so far GMC has refused’

'Stop the wasteful process of appraisal that is overly costly, does not promote or maintain public confidence, professional standards or conduct and admit that the process has never singled out concerning individuals or put them on their radar early.’

'Anonymity for the Dr as well as the “victim” until investigations are complete.’ (Other healthcare professional)

There were a number of respondents who called for the introduction of regulation of medical management, saying for example ‘...In order to actually fulfil the aforementioned duty, the GMC must widen its scope of regulation to include executives and managers of hospital and healthcare systems.' 'Legislators have a duty to the nation to bring regulatory rules to medical management levels including ensuring even distribution of complex cases and emergencies.'

The Royal College of Anaesthetists add that ‘Consideration should be given to the role of managerial accountability and system failures when deaths occur in healthcare; currently individuals incur a higher risk of legal proceedings than the organisations they work for. This balance needs to be redressed, especially if system failures have been found to play a part in the death of a patient.’

The Association of Anaesthetists Trainee Committee advise ‘it is also important to consider the consequences on the individual doctor and team who may be involved in a mistake.’

An academic advises ‘...The public need to have trust in hospital investigations. But doctors and hospitals terrified of press and litigation fees - it is a mess. Why not a system like New Zealand’

‘There should be an obligation to refer to police’

‘I think that the GMC has lost the confidence of the medical profession. My experience of it as RO as a GMC assessor for health cases and as an expert in cases where a doctor has been accused is that:
1. it is slow
2. it uses terms worthy of Harrold Pinter (still)
3. it is rigid, arbitrary and controlling
4. the way it treats its own experts and witnesses is contemptuous and uncivil
5. The cases of clinical misconduct that come to it are random and the standard they are judged by is random
6. it continues to confuse "bringing the profession into disrepute" and "being fit to practice medicine"
7. it’s attitude to doctors with mental health problems is highly discriminatory.’
Independent review of gross negligence manslaughter and culpable homicide
Question 49. What information would you like to see from the GMC and others about the role of reflection in medical practice and how doctors’ reflections are used?

There were 522 responses to this question online. 353 responses were from medical professionals.

The role of reflection in medical practice

The GMC advises in their submission that ‘...Reflection is a key component of Good Medical Practice (Domain 2) and an overarching principle of our requirements for revalidation as outlined in our Guidance on supporting information for appraisal and revalidation. The ability of doctors to reflect during appraisals (including ARCP’s for doctors in training) as a supportive and developmental forum, is central to their ability to improve the quality of their care. Regardless of the nature or scope of a doctor’s practice, ongoing reflection is an important part of being able to learn from their practice. It is not enough for a doctor to simply collect supporting information. Responsible officers can recommend that a doctor’s revalidation is deferred if they do not believe they have sufficiently reflected on or discussed their supporting information, and ultimately, if a doctor is persistent in not meeting that requirement, the responsible officer can make a recommendation of non-engagement.’

The General Pharmaceutical Council also highlights that ‘...Reflective learning, openness and transparency plays a vital role in ensuring mistakes are learned from and not covered up. It is essential that we have a learning culture across healthcare and we are committed to ensuring we play our part in achieving this.’ They point to their standards and guidance which are intended to make clear that ‘...pharmacy professionals must speak up when things go wrong ...and for registered pharmacies set out that pharmacy owners have an obligation to support pharmacy professionals to do this and promote a culture of openness, honesty and learning.’ They add that they are just beginning the introduction of revalidation for pharmacy professionals, which has been ‘designed to support and encourage reflection.’

NHS Improvement advise that whilst ‘reflection is a key part of clinical practice’ They are ‘...advised that the content of reflective practice has rarely, if ever, been used to the detriment of individuals in legal or professional conduct proceedings. However, the GMC should continue to regard a lack of insight or reflection as a possible reason to consider more severe sanctions. However; ‘self-reflection’ in response to incidents should be recommended with great caution. Investigation reports often infer that error is the fault of individuals, by recommending periods of self-reflection or retraining to prevent incidents recurring. This (although not always intentional) can result in individuals feeling blamed. Self-reflection cannot resolve systems issues which typically cause incidents to occur. Such issues can be overlooked/ neglected if the primary focus is on the individual.’

Confidential/Private/Protected

Some respondents state that reflections are, and/or should be, personal, private and confidential. The word ‘confidential’ is used 52 times in online responses, ‘personal’ 43 times, and ‘private’ 47 times. Many go as far as to say that they need to be legally protected (or privileged) and never shared without the doctor’s permission. The word
‘protected’ was used 25 times in online responses, ‘protection’ 20 times, and ‘privileged’ 22 times.

One says reflections should be confidential as this is the only way that doctors will be truly reflective and this is when reflections are valuable. They go on to say that ‘if documents are required to evidence individual performance these should come from a formal performance management system.’ Another adds that ‘...reflections are essentially private thoughts written down’.

Several references are made to other types of privileged information/communication: Confidentiality between lawyer and client, medical notes and religious confession.

Law Society of Scotland say that they support the promotion of no-blame culture to encourage doctors to reflect on mistakes where they arise so that lessons can be learnt for all concerned... Since reflection is fundamental and intrinsic to the medical training process, the ability to reflect honestly must be preserved. Otherwise doctors cannot be encouraged to be honest in their reflection. Honesty is what families interviewed in connection with the FAIs [Fatal Accident Inquiries] want- which is for this not to happen again or for the death not to be in vain as processes will have been reviewed and steps taken to avoid such outcomes in the future. How to preserve... balance is more problematic. The notes of the medical team’s review would be wider [than an individual’s personal reflections] where we can envisage that these may well be referred to at a FAI to show that changes in practice have been made in response to any death.’

Royal College of Physicians of Edinburgh suggests that ‘...the aviation industry model is worthy of further examination, as this has delivered full disclosure for learning by valuing reflective practice and, to a certain extent, excluding it as a record available to other agencies.’

They go on to add that ‘...If the NHS Board/Trust has other procedures (for example Mortality and Morbidity meetings and event reporting) to promote safety culture and how events are recorded, this should be encouraged and supported from board/trust level. Board/Trust level processes should also be clear on confidentiality, recording and sharing of outcomes and should similarly encourage candour rather than promote defensiveness.’

Many call for the GMC to support legal protection of reflective notes, some express an expectation that the GMC either have the ability to stop the courts from accessing written reflections or they should push for the law to be changed so that they can’t.

The GMC wrote that they ‘...told the Williams Review into Gross Negligence Manslaughter that doctors’ reflections are so fundamental to their professionalism that the UK and devolved governments should consider providing legal protection. We also reiterated this position in our evidence to the Joint Committee on the Draft Health Service Safety Investigations Bill.’

Jenny Vaughan makes a ‘...call for enhanced protection of reflective notes...Doctors in training to become consultants are required to keep notes, known as ‘reflections’, in which they record frankly their own performance. Disappointingly, legal protection has not been given to these notes, which in the hands of a prosecutor may be (and have been) used to
help convict a doctor of negligence. It is relevant that the Australian and New Zealand College of Anaesthetists (ANZCA) seem to have obtained enhanced legislative protection for reflective notes and reflective parts of their training programme...This protection, however, does not mean that reflections are beyond the reach of the criminal law. It raises the obvious question as to whether more could be done to improve things here in the UK. Many doctors would support any commitment by the AOMRC to work towards this.’

Scottish Independent Hospitals Association (and other individuals) warn that ‘...If reflective practice is able to be used in evidence in such cases, it will diminish the learning value to a doctor. In light of this case, it is likely that going forward many doctors will be sensitive to the wording they use and what they record in their reflective practice.’

The Royal College of Anaesthetists (RCOA) argue that ‘...steps must be taken to ensure that doctors’ reflections are not used in an adversarial fashion in judicial proceedings or by healthcare regulators.’ Noting that the GMC has committed to not doing so. RCOA ‘...encourage the review to consider making robust recommendations around the legal protection of doctors’ reflective materials in criminal investigations and court proceedings.’

The Royal College of Pathologists also argue that reflective learning needs to be confidential ‘...if it is to truly be a learning tool rather than something to help inform a blame culture.’

The Hospital Consultants & Specialists Association agree that ‘...reflection in medical practice ...should be formally barred as evidence. They go on to express disappointment that the Williams Review failed to recommend this step.’ The Muslim Doctors Association also highlight that the Williams Review recommendations didn't call for protection of reflections from criminal proceedings and ‘...would like to see the department of health put measures in place to protect doctors' reflections from being requested in courts.’ Some think that reflections are only to be known between the doctor and their appraiser.

One says that the only time confidentiality should be broken is if there is an indication that the law has been broken but that ‘...death is not a given indicator of breaking the law’.

**Written reflections are not evidence**

There are several comments on the unsuitability of using reflections as evidence as they are subjective and often written immediately after of the event. Several respondents say that doctors are naturally very self-critical so reflections on mistakes are not necessarily accurate or proportionate.

‘The nature of reflections is that they are subjective and may change with time, experience.’

‘They are words not actions.’

A couple of respondents say that using reflections as evidence goes against an individual’s ‘legal right to remain silent’.

‘Anecdote is the lowest form of clinical evidence.’

The Faculty of Intensive Care Medicine & the Intensive Care Society say that reflective practice ‘...is usually written at a time of heightened emotional stress and is a method of starting to process that emotion. It is often unrepresentative of how the doctor has actually functioned as it is entirely, and intentionally subjective and may be written at a time of
intense personal self-criticism which on subsequent review may no longer reflect the views of the individual.’

Some also say that some people are not naturally reflective - meaning that personality factors may render reflection useless. For serious incidents they feel face to face reflection is more valuable as it means the doctor needs an ability to appreciate others point of view and to demonstrate self-awareness and mental flexibility. They don’t feel that this can be gained from written reflections.

One respondent says that reflections are only relevant in an investigation if there are patterns or repeat problem without evidence of learning.

Some respondents say that they shouldn’t be used against a doctor because they are a learning tool.

Another expands on this area to say that reflections should only be shared with the permission of the doctor.

One respondent (categorised as other healthcare professional) warns that ‘...careful consideration should be given to forcing any action let alone reflection - the act of forcing reduces the individual's engagement and dilutes the educational impact.’

**Verbal not written down**

Some say that reflection should only be verbal, not written down. This is mostly because if it is written down, it is seen that it can be used for purposes other than learning. For a few it is because they feel the value comes from the discussion with more experience clinicians and colleagues.

A few say that the GMC only need to know that reflection has happened effectively ‘they don't need to see content.’

NHS Providers say that several Trusts are encouraging doctors to engage in timely reflective practice through verbal discussion with their supervisor (just noting that the discussion has taken place and actions agreed), which ‘can reduce the need for formal portfolio reflection’.

‘Reflection needs to be recognised as a process not an event’

**Too time consuming**

Several respondents say that it’s too time consuming to write down reflections and that it’s a better use of time to reflect in your head or in person.

One says that doctors ‘need time to accurately reflect, our Trust allows itself 45 working days to respond to a serious untoward incident’.

A medical student respondent advises that the emphasis on reflection is overtaking core skills and competencies which is ‘...frustrating for trainees and students’.

**Vulnerable**
Several respondents note that reflection is most useful when things ‘haven’t gone as well as could have’ and that for reflection to be most effective, a doctor needs to allow themselves to be vulnerable.

**Trainee vulnerability**

Several respondents highlight the particular vulnerability of trainees. They are the most likely to make mistakes and have the most to gain from reflective practice.

One respondent says that they find it worrying that in the Bawa-Garba case ‘it wasn’t her reflections that were used but her supervisors’.

One respondent says that ‘trainees must have complete control [over their reflections] and know who may see them’.

**A future without reflective practice**

A significant number of the respondents say that reflection should stop either because they see it as a waste of time or that there is no value in it in the current form.

**Waste of time**

Several respondents don’t see the relevance of reflective practice and feel it should be eliminated: One calls it ‘sanctimonious rubbish... a waste paper’ and another says that ‘reflection comes in consultation... writing reflections down is a waste of time’

Another just says ‘navel gazing’.

‘Reflection is a ridiculous activity that may suit some learners styles, but I am unaware of any evidence that it is of much benefit overall or particularly for those who find it pointless’

‘Little scientific evidence that reflection services a purpose’

One who has completed an MA in education says, ‘research into adult learning shows written reflection is less valid’

‘Reflection is flawed, good doctors reflect even if not written down...poor doctors will fudge paper work...appraisal process is about box ticking...administrators are good at appraisals, good doctors are busy practicing’

‘Tick box exercise’

‘Just a paper exercise’

‘Most reflections are waffle to satisfy that box’

**Too high a risk**

Several say that risk is limiting or undermining reflective practice:

‘[The] difficulty is that reflection is with another doctor who is under a GMC obligation to report substandard practice’

‘I approach written reflections as if I were under police caution - anything I do write might be used in evidence against me...The GMC should be honest and say that until the law is
changed, written reflections carry significant risks - their last statement was quite disingenuous in this respect.’

**Information/input requested from the GMC**

Many respondents call for confirmation that written reflections won’t be used against a doctor. Within these comments most stipulate that they mean not used in GMC/Fitness to Practise hearings, many additionally say they shouldn’t be used in court – repeated phrases are that a ‘clear statement’ or ‘guarantee’ are needed.

The Royal College of Paediatrics and Child Health say that they have received ‘...conflicting messages from the GMC on whether reflective notes will ever be requested from a third party such as a royal college.’ They say that most doctors are far more concerned about their regulator requesting reflective notes that the potential for the criminal justice system to request them.

An individual writes ‘...[We need] an unambiguous statement from the GMC that it’s not admissible in FTP proceedings' Related to this, one respondent asks, ‘can one doctor’s reflections be used against another?’ A couple ask for clarification on who owns written reflections.

**No input wanted from the GMC**

One respondent says: ‘NONE!!!! None!!!! Is this clear to the GMC?’

**Guidance on best practice**

There are a number of medical professionals that would like further guidance from the GMC on what to write and what not to write in their reflections. The word ‘guidance’ was used in online responses 46 times. One also asks for further guidance on how best to learn from reflection.

The Royal College of Surgeons of England say that through their Joint Committee on Surgical Training (JCST), they ‘...have been actively promoting the AoMRC’s Summary guidance: Entering information into an e-portfolio that sets out the principles of reflective practice for doctors in training.’ They also indicated ‘support for the GMC’s decision to revise its reflective practice guidance in conjunction with the AoMRC, British Medical Association (BMA) and the Conference of Post-Graduate Medical Deans (COPMeD) and look forward to its publication in the summer.’

It is worth noting that ‘the reflective practitioner’ guidance for doctors and medical students, developed by the Academy of Medical Royal Colleges, the UK Conference of Postgraduate Medical Deans, the General Medical Council, and the Medical Schools Council, was published (on 12 September) shortly after this questionnaire closed.

The GMC told us that some key messages in that guidance are:

- Reflection is personal and there is no one correct way to reflect.
- The quality of reflections is more important than the quantity. A variety of different experiences can be reflected on.
Having and taking time to reflect on both positive and negative experiences – and being supported to reflect – is important for individual wellbeing and development.

Group reflection often leads to ideas or actions that can improve patient care.

The healthcare team should have opportunities to reflect and discuss openly and honestly what has happened when things go wrong - see Openness and honesty when things go wrong: the professional duty of candour.

Doctors should keep notes to demonstrate they are a reflective practitioner, this does not need to capture full details of an experience but show awareness of how to learn and develop from both good and bad experiences.

Doctors in training should discuss the experiences they have been reflecting on with their supervisor. They should include in their learning portfolio insights gained and any changes made to their practice. The supervisor should in the portfolio confirm the experience has been discussed, and agree appropriate learning outcomes and what actions are planned. They should share original, non-anonymised information with supervisors but should not record factual details in the learning portfolio.

Doctors undertaking appraisal should discuss the experiences that have been reflected on with their appraisers, and maintain a note of these discussions. These notes should focus on the learning identified and any planned actions. No factual details should be recorded in the appraisal portfolio.

When keeping a note, doctors should anonymise it as far as possible. Our guidance on confidentiality explains what is expected.

The GMC will not ask for reflective notes as part of a fitness to practise investigation – though doctors can choose to offer them as evidence of insight.

Reflective notes can currently be required by a court - if doctors have followed the advice on anonymising data in reflective practice notes and considering the learning from experiences, this should not be a cause for concern. It’s important to note that as reflective notes are not contemporaneous records of an incident, they are less likely to be of interest to the courts.

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Tutors, supervisors, appraisers and employers should support time and space for reflection, individually and collectively.

Royal College of Obstetricians and Gynaecologists say that ‘...RCOG trainees have reported taking a more defensive attitude towards the written process of reflective learning in e-portfolios.’ They therefore ‘...support the suggestion of an education/communication campaign aimed at trainees, to reiterate the value of reflective learning and the risk to their development of not undertaking reflection.’

The Association of Anaesthetists Trainee Committee ‘...understand that reflections are being considered as part of the draft Health Service Safety Investigations Bill and hope that this may provide more clarity on their status. It is important that any guidance issued is consistent with the draft legislation.’

The BMA argue that ‘...the GMC should focus not on providing information about the role of reflection in medical practice, which might be seen as patronising, but on simply telling doctors what practical steps they need to take. It should outline a wide range of ways of meeting the requirement to reflect and let doctors use their professional judgement to determine what works for them. It should make clear that it is acceptable for doctors to reflect in group discussions rather than alone. It should also make clear that it should not be necessary to reflect in writing (e.g. on e-portfolios) and that it is sufficient to provide evidence that reflection has occurred rather than provide the reflections themselves.’

**Change in the Medical Act required**
The BMA also ‘...recommend that the law should be changed to ensure that the GMC cannot compel the disclosure of information provided for the sole purpose of education and training.’

Doctors’ Association UK agree and say that ‘...although [updated] guidance exists, doctors are still concerned that their reflections could be used in court against them. As a result, there is a new reluctance to produce written reflections...reflective practice is essential but that it is not necessary to actually provide written reflections in portfolios. The evidence of reflective activity taking place should be sufficient...medical reflections should be subject to legal privilege. GMC assurances that it would never require a doctor to submit reflections is a step forward but needs formalising with a change to the Medical Act 1983 which refers to disclosure.’

**Isolated requests for information**

One respondent goes into more detail in guidance asking for ‘more advice on avoiding emotional responses [when] describing the event immediately following the episode’. They also wanted advice on a ‘reflective template’. And, asked for advice on how to deal with ‘lower level case such as compensation claims asking for copies of reflection notes’.

NHS Providers suggest that the GMC ‘...should collate a number of anonymous reflective practice pieces into one document for each specialty which could be shared through professional networks.’

One says that they want the ‘GMC prioritise blame free culture’ and that the ‘GMC needs to state clearly that mistakes are normal even ones that end in death’.

Another says that they want ‘specific advice how to whistle blow when there are organisation and system pressures’.

And another wants to know ‘what GDPR means to any written records that involve reporting even if anonymised’.

A small number say they want less input from the GMC or nothing at all. One says that the GMC ‘should make no further comment on the subject at all’.

One says that the ‘GMC will find it hard to issue guidance in current climate’.

Another says that the GMC can’t be trusted, their ‘reassurances aren’t believable.’ Similarly another respondent says that there is guidance from the GMC on reflective practice but that they have ‘...no confidence in its analysis or understanding of the issues involved for practising doctors.’

**The future for reflective practice**

Some respondents state that honest reflection is only possible if there is no threat of prosecution – they need to feel safe in order to reflect openly. It is also note by a few that the most important reflections come in response to mistakes.

**Perception of GMC actions**
There are mixed perceptions of the GMC's actions in recent events. Many think that the GMC either requested a doctor's written reflections and/or are not being honest about their actions. One states that there is 'evidence that the GMC have asked to see reflective action'. Several ask to simply be given honest information.

One respondent based outside of the UK says that they don't know the full details but think reflection was abused.

One stated, 'trust has been destroyed. There are vague soothing emails issued by the GMC, and a whole host of other bodies that are written in legalese, with loads of caveats that are impenetrable to trainees. ... Junior doctors need simple (bullet point), unambiguous, and legally binding guidelines on the use of reflection'.

'GMC has no right to tell others to be honest when they are conceding truth and bluntly lie in their own court'

'The GMC are trying to wriggle out of mistakes...why is GMC trainer and judge at the same time?'

**Current climate**

Several say that light of recent events around the Bawa-Garba case, the ability to honestly and openly reflect has been damaged and that there is no trust that the GMC didn’t and wont used reflections against a doctor. One stated that the negative impact of this will last for 20 years.

There are a couple that have knowledge of the GMC stating that reflections wouldn’t be used against a doctor but can be brought forward by the doctor themselves if they so choose. Though, from these respondents it’s noted that more is needed from the GMC.

'The GMC has stated it does not require submission of reflections when investigating cases, and this advice could be repeated regularly until it is widely known.’

'It needs to be clear the GMC won’t use reflective notes but also that GMC has no control over courts’

**How the healthcare system uses reflections**

**Censorship**

'From my revalidation I know that if I wrote anything remotely honest I was asked to remove it and re-word it. To make the process look more honest (ironically)’

'Reflections are being censored’

**Misuse of reflections**

There are a couple of respondents who suggest the reflections are used against doctors within the healthcare system.

One respondent says that they are aware that ‘PDP was used to order new evidence (medical records) against [them], to raise new allegations’ they say that the case was abandoned but it has left them unwilling to write reflections down.
Another says, ‘Knowing that HBs have compelled disclosure of reflections which were guaranteed confidential, I would never believe any GMC assurances… confidence in GMC spoiled by HB managers - threats of referral to GMC for failure to comply with investigation’.

‘Foundation hospitals and medical directors used them to entrap (names available) If you disagree with them they say you lack insight…unprosecuted med director of a trust with high cancer death rate ended many doctors’ careers ordering them to reflect and then using it against them’

There is one reference to the ‘bully nature of the NHS’.

The BMA claim that ‘…the Ombudsman in Northern Ireland has the power to request the disclosure of legally privileged documentation and has done so on a number of occasions. Although it is rare and unusual for the courts to order the disclosure of reflective notes or statements, they retain the ability to do so.’

**Broader use of reflections**

There are couple of respondents that thing there is value in wider use of reflective notes in an anonymised form, one saying, ‘I appraise and the number of times I see the same incidents occurring again and again, usually hospital related and no forum to collate these and feedback since 2013 NHS England reorganisation. Used to be encouraged at Pct, CCG do not do this’.

One medical professional argues that ‘…reflective practice is a powerful way to learn and improve. However if the first opportunity to reflect on the death of a patient and manslaughter charge is 10 months down the line after all the investigations, then it is too late. Also reflective practice has little meaning with someone who knows nothing of the problem or is part of reflection on everyday aspects of work in which there is no concern. This dilutes the benefit of the process.’

One respondent (categorised as other) describes how they think revalidation should work and how reflection should fit into the process (this is a fairly accurate description of how revalidation does work). In addition, they think that ’part of the reflective process should be witness statements from staff. Complaints should also be part of reflective practice.’

Another respondent (categorised as other healthcare professional) feels that reflection is only useful if done with proper structure. They say that reflection ‘remains too 'cosy'. How do we know that doctors are reflecting on the right things? That actions are followed through where reflections reveal improvements should be made? I believe in that regard that the link between revalidation and reflective practice is currently too weak.’

**Other opinions**

‘Can the GMC executives publish what lessons they have learned?’

‘I don't personally think that there is an issue with reflections, or that it has much relevance in the case of Dr Bawa-Garba.’

**Patient or family member of a patient (11 responses)**
Five patient or family members seemed to agree with the majority of medical professional’s responses to this question, saying that ‘...Doctors’ reflecting on their practice has been enforced as part of their mandatory review process since Shipman. It has been shown to improve practice, but it has been protected in the past as confidential. Taking away this protection means that doctors will choose not to reflect on their practice for fear of reprisal. This will ultimately have a negative effect on the learning and professional development of doctors.’

Similarly, three other patient or family members agree saying, ‘...reflection should be private,’ ‘Honest system, honest culture,’ and ‘... I don’t think it should be admissible. Otherwise any reflection will not be an honest process and therefore pointless.’

Another adds that ‘...They [reflections] are too subject to bias, to writing what the doctor thinks they should write. The most diligent of people will write anything. They should not be relied upon. They should be private. Most importantly, many people are not naturally reflective and there may be individual personality factors whichever would render reflections on their own worthless. In serious incidents, I feel face to face reflection with the doctor would be much more important-what you are looking for is the doctors ability to appreciate another point of view (patient etc.), when the e consequences of their actions are pointed out that they can see them, that they can intellectually project future ramifications. In summary, they need to demonstrate self awareness (unconscious bias, consequences) insight to the situation and mental flexibility. This will not come out from written reflections. Written Reflection is best used when it is spontaneous, and particular to that doctor.’

One patient or family member didn’t seem to think that reflection could enhance patient safety saying ‘...Reflect on the fact that the free NHS is too basic and I do not personally use it any longer unless in an absolute exception and nothing will ever make me change my mind. Reflect that free is not free as the money comes out of taxes as does the compensation paid to people etc. The current system is too unsafe and no reflection will make it safe.’

Other family member or patient responses indicated that they didn’t know what reflection means or made other comments such as:

- ‘To learn to STOP patronizing as they know it all, and diligence it’s a must in this profession!’
- ‘Reflections? I don’t want to know about what they are thinking they have a job to do and we would like them to do it well.’

A member of the legal profession simply states that ‘...There should be no cover up, transparency is in the public interest.’

A Patient representative organisation says they ‘...have so many reservations about reflective practice... it needs to be abandoned. The whole subject needs to be started again and thought through in the light of experience. (And I am not a medic).’
Question 50. What emotional, pastoral and other support is available for doctors who have an allegation or charge of gross negligence manslaughter or culpable homicide and are being investigated by the GMC?

There were 458 responses to this question online.

A number of themes identified in the previous responses to questions about support available for doctors in other processes (local investigations, coronial/PF proceedings and criminal processes) were identified here again in relation to support for doctors during GMC fitness to practise processes.

The majority of respondents either stated that they didn’t know of any ‘formal’ support available, they believe there is very little available, or that they didn’t know where to find support or that it isn’t ‘advertised/publicised well enough’. The word ‘limited’ was used 10 times, ‘unsure’ 12 times and ‘variable’ 9 times.

Many of those that did name options, stated that there wasn’t enough available (including, for long enough) and/or that it is inconsistent or dependent upon a number of factors (including a doctor’s ability to ask for help and available funding sources). Many raised significant concern with the lack of support and some highlighted the suicide rate amongst doctors, and in particular those under investigation (‘suicides’ – 12 times). With some stating that the support is ‘...obviously not good enough by evidence of rate of suicide.’

Sources of support

A number of the identified sources of support here, reflected those that respondents referred to in answer to the previous question asking about support for doctors following a serious clinical incident and local investigations (Q26):

- Medical Defence Organisations (‘MPS’ 12 times, ‘MDU’ – 11 times, ‘medical’ – 17 times, ‘defence’ – 20 times and ‘organisations’ – 18 times), although noting that ‘MDOs focus on clinical case’
- BMA/Unions (‘BMA’ – 44 times and ‘unions’ - 8 times)
- ‘support and signposting from the GMC’
- Colleagues/peer support (‘colleagues’ – 32 times) ‘often individual educational supervisor/clinical director/medical director
- A doctor’s GP
- Family (‘family’ - 17 times)
- Friends (‘friends’ - 18 times)
- Counselling (‘counselling’ – 12 times)
- Pastoral or legal (‘pastoral’ – 8 times and ‘legal’ – 7 times)
- Charities (including the Samaritans)
- Doctor networks
Variable

Many respondents noted that the availability of support is: variable, often informal and can be dependent on a number of factors. For example, the Association of Surgeons GBI say that the ‘...support of the relevant postgraduate deanery will be available for doctors in training. For senior clinicians, the arrangements are more variable and rather ad hoc. No formal arrangements exist, although senior doctors will usually seek and receive support from their colleagues, a clinical director or clinical governance lead. Occupational Health departments may be able to provide psychological support. Educational and professional support is usually a matter for the relevant specialty associations, whereas legal support is usually the remit of the relevant defence organisation.’

In relation to the Mental Health Practitioner Programme, respondents commented that there is ‘PHP in London’, but, ‘if not covered, this is astronomically expensive-well in excess of the means available to junior doctors-otherwise it relies on Trusts.’

Other views on variable support:

- ‘There is support available within my Trust in addition a supporting culture is encouraged within my department. I am not aware of there being a formal programme of support - perhaps there should be one?’
- ‘At the GP level there may be large amounts of support available. Our LMC (Beds and Herts) is particularly in the forefront here. However, I suspect the extent and type of support is variable across LMCs.’
- ‘...depends if your supervisor is supportive and your specialty.’
- ‘...depends on where they work. Speaking as a GP Educator we offer a huge amount of support to trainees. As a GP locum, I would probably get little support and would need to actively seek it.’
- ‘When in a GP practice the level of support would depend on the colleagues you work with - it might be good or v poor.’
- ‘Trainees have access to professional support units.’
• ‘External organisations will usually involve the doctor paying a subscription.’
• ‘Only what arrange for them selves’
• ‘Nothing standardised’

**Issues with anonymity of doctors who seek support and the independence of the support available**

• ‘[They] know you, your practice and people around you. It’s not anonymous.’
• ‘Supposedly the HBs and CCGs provide OH services, but they cannot be considered confidential or unbiased.’
• ‘Many doctors do not see their organization’s occupational health departments, to where they are often referred by management, as neutral and independent.’

Several note that availability is variable depending on location:

• ‘Herts and Beds the Local Medical (GP) Committee has a pastoral care service.’
• ‘A confidential counselling service in Wales’

**Not enough**

Dr Oliver Quick advises that ‘...the overwhelming impression I have listening to clinicians is that the support is woefully inadequate.’

Indeed, a number of individual respondents would support that impression:

• ‘Limited and biased to departmental directions or image.’
• ‘None I suppose unless they pay for it out if their own pocket’
• ‘No unbiased support’
• ‘Our local trust does not even have a common room for doctors to talk in and learn from each other and decompress. This is grossly negligent of stressed colleagues. The firm system of teams allowed mutual support and worked well for two hundred years. Gone!’
• ‘It should not reach this point. Any emotional self-management should be part of training “for when things go wrong.” This should be part of under- and post-graduate curricula.’
• ‘Poor for low level case worse for more serious ones’

**Other issues with support that is available**

• ‘The Department of Health’s support to this seems to consist of advocating ‘resilience training’ and wondering why it’s difficult to fill staff vacancies. There needs to be national recognition that if the country wants NHS staff to care for its citizens, these citizens also need to care for NHS staff, especially when they don’t get things right (many of my colleagues are deeply affected by losing patients).’
• ‘There also needs to be some consideration to what happens if false accusations are made and if there should be any comeback on individuals making claims that are proven to be false.’

**No financial support**

One respondent notes that there is no financial support, another that hospital doctors get less support and that what’s available depends on particular supervisor or specialty.

• One respondent states that they worry most about junior staff and BME staff often those from abroad have little external support.
Long(er)-term support is lacking

- ‘there is hardly any long-term support for such doctors. Most people pass the blame on to individuals and distance themselves from them.’
- ‘support for doctors in the acute aftermath of a fatal incident is well organised. However the long-term effects of an on-going investigation have till recently not been well recognised and I think more can be done locally and nationally to better help doctors in these situations.’

Barriers to accessing support, self-care and asking for help

- Perhaps mandatory one off assessment for those in need of support may not recognise the need
- ‘GPs struggle to attend their own GPs due to stigma’
- ‘There is probably a lot available, but unfortunately doctors tend to be very bad at looking for support of that nature, we tend to think we should be strong enough and capable enough of getting through anything on our own. protecting them from press intrusion might be a start…’
- ‘Many doctors are crippled by the high expectations that come not just from the public and the profession but from themselves – we can be our own worst enemy. The culture of medicine is sick and encourages doctors to NOT be open about any frailty, weakness or mental ill health and is exacerbated by the punitive stance the GMC takes to such issues.’

Isolation, loneliness and vulnerability

It was evident from responses that there are strong perceptions that doctors are isolated whilst under investigation. There were several factors which respondents felt contribute to this. We are told for example that ‘... Most trusts suspend doctors and forbid them to contact other staff members or visit the premises.’ We are told that this banning of doctors from speaking to their peers (who are a potential source of support) is ‘extremely damaging to individuals professionally and mentally’ and that ‘there is good evidence of increased self-harm / suicide in these cases’

We are told that doctors can feel or be ‘shunned by colleagues and are very vulnerable.’ And, that ‘...suspension whilst under investigation is a very distressing experience for the doctors.’ Particularly when ‘...organisations do not necessarily look after the doctor,’ or ‘some doctors seem to be abandoned by their employer and their support needs are not met in any appropriate way.’

We are also told that ‘...once the doctor is suspended, the hospital may not know what support they need. One medical director tells us that they ‘did support doctors who had fatalities’ and they add that ‘continuing to work helped their confidence.’

One medical professional tells us about their experience:

‘When I was being investigated by the GMC (for a much more minor affair) my feelings of loneliness and vulnerability were ameliorated somewhat by representation from the MPS, from some patchy sympathy from my hospital, and mostly from informal contacts (family etc). I believe that in serious cases, zero sympathy from the hospital is the norm.’

The Doctors’ Association UK say that, ‘there is very little emotional and pastoral support available to doctors. Often doctors feel isolated, judged and humiliated when under investigation. Most doctors also feel alone whilst under investigation, the inability to work, interact with friends and colleagues leave them vulnerable and susceptible to mental health problems. The length of GMC investigations and their nature also serves to worsen the
problem for many doctors. Quicker case assessments are required by both the GMC and CPS. We have seen far too many doctor suicides whilst under investigation or after the conclusion of investigations. The impact of these investigations spreads much further than individual doctors too, to their families and friends. If the GMC really do claim to be supporting doctors, then the commissioning of an independent service to support doctors through an investigation should be provided from doctors’ registration fees. Simply providing a list of alternative organisations is not sufficient in our opinion given the cost of registration fees.’

One medical professional adds that ‘...Once the doctor has been sacked from the hospital and the GMC she/he cannot go near a hospital, nobody expect his/her close friends will want to have anything to do with them.’

Medical and Dental Defence Union of Scotland (MDDUS) say they adopt a double handed approach (both medical and legal adviser support) and ‘...work with other agencies such as the Royal Medical Benevolent Fund, the BMA’s Doctors for Doctors Service (which is more extensive than the version provided via the GMC), and also are sensitive and proactive about directing our members to their GP and/or occupational health services where necessary.’

**Multiple Jeopardy**

The MDU highlights the support package they provide their members but highlight that ‘...in too many cases it seems our members have little or no access to any other support, formal or informal, outside the trust’s occupational health department. And, while an unexpected death and all that an investigation for GNM entails are daunting enough, it is important to remember that doctors are, unusually, subject to multiple jeopardy. They may be, and in these sorts of cases often are, also subject to a range of other procedures from employers’ and regulatory investigations to inquests, complaints, claims and, as we have observed above, very often trial by media in such cases. While they have the support of the MDU throughout, there is very little else available to them.’

**Impact on those around the doctor**

We are told that:

- ‘The effect on the family seems to be forgotten too’
- ‘GMC and other public bodies should understand they have their family who is taking the brunt of the stress although they are not responsible.’

**About the GMC ‘support’**

Some say there is none from the GMC or that the GMC needs to take a more supportive or sympathetic approach towards doctors. For example, the Royal College of Anaesthetists identify that ‘...greater support needs to be available to healthcare staff involved in investigations by regulators and the authorities. In addition consideration needs to be given to the effects of serious incidents on all healthcare staff involved as ‘second victims’.

One medical professional who shares their personal experience of being investigated for GNM says that ‘...the GMC the approach is just as bad [as local investigation’s support offer which they described as appalling] though with less direct involvement. You feel guilty and
are talked to in that way. Also the people you talk to often have poor factual knowledge on the management of these cases and offer inadequate advice. Having said that the Interim Orders Panel seems to be a neutral and more objective forum if not directly supportive. I would like to see their recommendations being applied to the trust so that individual trusts cannot act unilaterally. Certainly if the IOP applies sanctions the trust will follow them. But if the IOP say a doctor should be allowed to work the trust will still bar them. This is wrong. Much of the harm caused by these cases is in the isolation and removal from the work place. This process is so harmful that many good doctors even after they have been cleared never make it back to work. I find this completely understandable but shocking that it is allowed to happen. In many cases this need not happen...It is hard to over-estimate the impact on the life of a doctor who has worked often for decades without any issues to suddenly be castigated in such a way. Recently it was recorded that 99 doctors had committed suicide while under investigation. Once the process has started it is unstoppable. A senior barrister said to me, it is in no bodies’ interest to stop the case, you have to let it run. Well I could think of someone who would be interested in stopping it. Plus a huge amount of NHS money is spent far away from health care.’

Seven individual respondents mention that the GMC provide support and signposting to other resources.

- ‘There is a GMC funded, independent helpline/support service for doctors being investigated.’
- ‘A GMC advisor visited our course for appraisers and explained that a lot of support is available. More GMC visits to junior doctor training courses to give a half hour talk would help to alleviate a lot of unnecessary stress among doctors.’
- ‘The GMC usually waits until the legal process has taken its course. Support for doctors being investigated by the GMC still leaves a lot to be desired (particularly if they are not supported by a defence society).’
- ‘I believe that the GMC is missing a trick here- there are a whole cohort of Associates all over the country who are involved in different parts of the Fitness To Practise process who are ideally placed to offer some local support for doctors who have been referred.’

MDDUS ‘...recognise and support the GMC’s stated commitment to make improvements in this regard following the Louis Appleby recommendations.’

The Association of Anaesthetists say they ‘...believe that the GMC should be required to assess and provide support as a component of the FtP process. The Practitioner Health Programme (PHP) should be extended and made available to all practitioners working in the UK. We note the new Secretary of State’s priority for action on workforce issues and believe the extension of the PHP, and, specifically, attention to the welfare issues of clinicians subjected to such allegations or investigations, would be consistent with acting as a caring ‘employer’. The suicide rate amongst doctors reported to the GMC is significantly raised. Of note, it should be the potential supporter who makes the initial contact with the doctor who faces the allegation.’

The GMC say they recognise that being investigated can be a stressful experience, and refer to:

- the independent GMC Doctor Support Service which they commission (currently delivered by the BMA) to provide support to doctors under investigation.’ The service offers emotional support from another doctor and is independent of the GMC and completely confidential. It is free to doctors and available to all doctors, not just BMA members...
In addition to relevant written information which is sent to doctors at each stage of the investigation process, we also provide information for doctors on our website to explain our investigation processes - How we investigate concerns.

Our Investigation Officers are also available to doctors under investigation to answer any questions about the process.

On the MPTS website, there is a dedicated section for self-represented doctors with comprehensive guidance, and information about sources of support, including a telephone information line, and the Doctor contact service, which is offered by the MPTS to doctors attending a hearing to help lessen isolation and stress, signpost useful support materials and services and provide information about the hearing process.

A recent programme of GMC's work to support doctors, (some of whom might be vulnerable) involved 26 changes to the fitness to practise process to reduce impact and increase sensitivity and support. Changes included:

- A single point of contact for any doctor under investigation and co-ordination of correspondence with these doctors
- A specialist team with enhanced communication training for cases involving doctors who are unwell, and the development of communication plans for doctors
- A process to pause investigations to enable doctors who are very unwell to get treatment.

**Support shouldn’t come from the GMC**

There were some respondents who felt that it would not be or isn’t appropriate for the GMC to provide support for doctors (because it is viewed as a conflict of interest), saying for example:

- ‘I am aware that the GMC is considering how to address this. I do not think however that the GMC can be supporter and investigator so maybe engagement with the royal colleges might be more appropriate’
- ‘I understand the GMC is trying to offer support. Yet the GMC processes, investigations and prosecutions of clinicians cause the problem.’

Whilst another respondent isn’t commenting about the conflict of support from the GMC they do argue that ‘...theoretically, employers may suffer a conflict of interest if they are asked to deal with both the consequences of a GNM event and the need to support the employee. This has not been my experience of NHS employers whose individual departments are sufficiently professional and disparate that this conflict does not seem to arise.’

**Impact on doctors facing fitness to practise proceedings**

The BMA also refers to the support service mentioned in the GMC’s submission above. They add that ‘...there is a significant psychological and physical morbidity experienced by those undergoing disciplinary proceedings with the GMC. The BMA is particularly concerned with the high suicide rate amongst doctors facing Fitness to Practice proceedings compared to the general population and those in prison.’

They add that ‘A doctor may also contact either BMA Counselling or our Doctor Advisor Service...whilst GMC matters are not part of the current remit for members, the doctors are encouraged to keep the BMA updated regarding their GMC case. The member/MDO will be provided with appropriate support, advice and representation regarding their employer’s policies, procedures and contractual arrangements. Additionally, support will be provided should it be necessary to refer an issue through the employer’s grievance procedure in relation to bullying, harassment, discrimination etc. In certain circumstances, subject to
merit, a member’s case may be supported at an industrial tribunal by the BMA’s independent legal provider.’

The Association of Anaesthetists Trainee Committee also refers ‘...the GMC funded free Doctor Support Service which is independently run by the BMA and provides confidential emotional support from fellow doctors although not medical or legal advice.’ They say they ‘...have a great interest in wellbeing and... offer a mentoring scheme which enables reflection leading to change which produces valued outcomes and helps to make a positive difference in anaesthetists working life or career. Although there have not been any trainees using the mentoring scheme following an allegation of gross negligence manslaughter, pastoral and emotional care will always be offered to members and non-members’.

One respondent, categorised as other healthcare professional tells us that they have ‘...been involved in providing emotional and educational support through coaching. It is important to provide this as no matter how horrified we may be by the event or even the actions, the doctor is still a human being and should be offered support in a non-judgemental way. It is possible to provide support to the individual without agreeing or endorsing their actions.’

The Royal College of Physicians highlight the significant pressures on doctors, referring to the results of their most recent census which highlights ‘...the rising pressure understaffing is having on doctors in all four nations and the dangerously long hours some are having to work. Issues with junior doctors are also evidenced, with trainees reporting a colleague calling in sick for up to half of all on-call shifts. Through no fault of their own they are working in an environment that is conducive to error, and error can have a significant impact on the mental and physical health of a doctor. For that impact to be compounded by being held individually accountable for the failings of the system, when you were acting in good faith, is inexcusable.’

Support from professional representative organisation, college or trade union

The Academy of Medical Royal Colleges advises that ‘...Colleges have not traditionally involved themselves in providing emotional, pastoral and other support for doctors whether facing a patient complaint or who have an allegation or charge of gross negligence manslaughter or culpable homicide and are being investigated by the GMC. There are indications that is beginning to change and two Colleges have recently set up support mechanisms and others are exploring the issues. Access to such provision is obviously important and has probably been overlooked previously. It is hard to see how this could be a role for the regulator if they may be taking action but they could certainly signpost to available services.’

The Royal college of Paediatrics and Child Health say they ‘...are currently reflecting on whether it can provide more support to members in these exceptionally difficult circumstances, and we know that other Colleges are currently considering the same issues.’
One respondent says they are aware that ‘...the Association of Anaesthetists has recently launched a system of mentoring which would be a useful resource - IF people are made aware of it at the time. Not sure if other specialties might have done the same thing.’

**Patient or family member of a patient**

Of the eight patient or family member respondents, five say they don’t know of any. One additionally comments that ‘support for doctors should be funded by doctors’ and another that ‘there is none for the relatives’

Two say there is not enough, one says, ‘It’s a smokescreen. I have lost someone I know due to proceedings. They died.’

One says there are many things available but most don’t know how to access’. One just says ‘Good sources’.
Question 51. How can the learning from a fatal incident best be shared? Should the regulator have a role in this?

There were 423 responses to this question online.

This question yielded a lot of responses highlighting existing initiatives to disseminate learning from fatal incidents. Regardless of which of the suggested methods the respondents state are used or should be used, we are told that it needs to be open, honest, sensitive and non-judgemental.

Does the GMC have a role?

The majority of respondents seem to say ‘yes’, about a third say ‘no’ and slightly fewer say they aren’t sure.

Yes the GMC should have a role in the dissemination of learning

Respondents generally indicated support for this, one so far as to see that they regarded it as the GMC’s duty ‘...to share such learning points.’ They add that they are sure ‘...the Public assume this is what they do already and should be doing to maintain public confidence’

Another adds that ‘...the regulator could have a role in this and it may be helpful for it to do so as it can then truly say it is about protecting patients and maintaining high standards of practice but in a practical and constructive way. It is also, arguably the best way to disseminate most widely amongst doctors in the UK that come under it's auspices. Perhaps even a CPD element to encourage maximum participation in the learning?’

Dr Oliver Quick identifies the key issues as ‘...Prompt disseminating of information as safety alerts to relevant staff. By empowering those at the sharp end of fatal incidents to feel able to talk / write about their experience. Ensuring that such sad cases lead to better guidance and support for clinicians.’ He adds that ‘...is hard to say that the regulator should not have a role in this.’

The Medical Schools Council say that ‘...the Regulator could disseminate key learning points to all GMC registered members and NHS trusts.’ The Association of Surgeons in Training thought the same.

The Royal College of Pathologists alternatively suggest that ‘...the regulator should provide a summary of specialty-specific learning points from MPTS cases. Examples of how this could work are seen in the Case Notes circulated by the Medical Protection Society.’

The Association of Anaesthetists say that ‘...the regulator can only fulfil its obligation to protect patients by promoting such learning. Of note, this responsibility does not lie with the regulator alone. For example, we welcome the increasing use by Coroner of the 'Prevention of Future Deaths’ notices.’

British Society of Gastroenterology highlights the role that representative organisations have in this area and believes that ‘...the regulator should definitely have a role in sharing good practice...Defence organisations such as MPS, MDU and MDDUS have been very proactive and constructive in this area. The regulator however frequently fails to use
professional groups to disseminate knowledge and the GMC should adopt a more inclusive approach.’

Royal College of Physicians of Edinburgh also believe that ‘...the regulator should be an active participant and contributor.’

The Faculty of Intensive Care Medicine & the Intensive Care Society agrees that the GMC should but warns that ‘...this needs careful analysis and thought about how to implement. It is probably done in conjunction with the medical royal colleges/ faculties/professional societies and a national reporting system.’

The Association of Anaesthetists Trainee Committee say that ‘...Learning from mistakes and fatal incidents... can be shared locally in departmental and Morbidity & Mortality meetings...The regulator can be involved in highlighting anonymised examples more widely and, more importantly, what the learning points have been and how departments have changed practice. This will enable departments to learn on a national level.’

The BMA advises that the ‘...best way to share the learning will depend on the kind of learning involved. If the learning involves improving training, for example, the regulator may need to require training providers to deliver the improvement. If system pressures have contributed to the incident, the regulator may have a role in highlighting the need for those pressures to be alleviated. We are pleased that the GMC has recently been highlighting the impact of such pressures... the BMA welcomes the introduction of ‘safe spaces’ by the proposed Health Service Safety Investigations Body (HSSIB) which will hopefully help to gain the confidence of healthcare professionals in the new body and contribute to the much-needed establishment of an open and learning culture across the health system. The BMA recommends that the HSSIB should have its processes given the same legal protection that exists in aviation safety investigations if it is to replicate its success in implementing system wide learning to improve safety processes.’

Faculty of Pharmaceutical Medicine argue that ‘...the National learnings across the NHS requires the holding of the register of all unexpected deaths. We presume that this will be with the National Reporting and Learning System. Alternatively we would propose that this is part of a role that could fall to the GMC to ensure best practice and adoption of changes in practice.’

Some respondents came up with ideas for what the GMC could do (although not strictly speaking disseminating learning):

- Hospital Consultants & Specialists Association say that ‘...the regulator should not be involved in the fatal incident investigation. The findings of an independent system-wide investigation may, however, pertain to areas of competence over which the GMC has direct responsibility. In such cases then clearly the GMC should have a role in implementing the recommendations which arise from any investigation.’
- ‘The regulator should have a role in unusual circumstances e.g. pattern of behaviour/errors’
- ‘The regulator could ensure that official documents such as coroner inquest findings are shared with all involved - these may be sent to the Health Board but are not thereafter circulated to anyone. Possibly these could be sent to Professional Societies for review in terms of whether it should be more widely disseminated in a brief summary of some aspects.’
• 'The regulator could have a role in clarifying which different specialty or generalist professionals should be given training relevant to each specific case'.

• 'Visiting the organisation and speaking to the whole group to avoid any future mishap can be very useful' 

NHS Improvement advises that ‘...Ideally, all regulators would support the development of systems and processes that maximise the ability of NHS providers to undertake and share effective and sustainable improvements in the delivery of healthcare to reduce the risks of incidents recurring. This would require regulators to support organisations to develop such systems, and focus on highlighting the importance of such systems.'

Enforced by GMC

• 'I think the GMC can help with this by mandating learning as part of revalidation’.

• 'Not specifically, but should seek evidence that the learning has been shared from Trusts’

• ‘The Regulator needs to work with Employers to monitor professionals’ engagement with their credible feedback, insight and action for their improvement - their 'Insightful Practice'.'

No the GMC should not be involved in the dissemination of learning

A number of respondents did not see a role for the GMC in disseminating learning Those that say that the GMC shouldn’t be involved, cite the loss of the profession’s confidence in the GMC as the reason why they shouldn’t, or that ‘...such responsibilities do not seem to fit neatly into the GMC’s current portfolio’. Similarly, the Association of Surgeons GBI ASGBI do not believe that the regulator (as least as the GMC currently functions) should have a role in learning from fatal incidents.

Several of those that do feel the GMC should have a role, share the view that the GMC have lost confidence of professional and suggest information would need to be provided via professional associations on our behalf or that could function similarly to coroners, highlighting areas of concern for DH to distribute.

One academic thought the ‘...only role for GMC is to encourage.’ A member of the legal profession advises that ‘...the difficulty here is that the GMC or NMC normally come at the end of a series of other investigations (Trust, Coroner, Police) and are often much delayed. The regulator seems quite often to be picking up the pieces from the previous investigations. They will instruct their own expert but by the time the case is in the GMC’s hands much of the learning will have taken place and the focus in the GMC (MPTS) is the adversarial contest which is not built for learning lessons.’

MDU also highlight the same issue saying ‘...When identifying problems and learning lessons from unexpected deaths, it is important to do this as soon as possible after the event, while all the evidence is still fresh, and in order to ensure as soon as possible, there will be no repeats. This is best done locally and by the organisation in which the death happened. Quite often the GMC investigates a case some considerable time after the incident and it will not have the whole picture but only the part the doctor under investigation played in it. For these reasons the GMC is not the best body to identify learning at the time it is most important to do so, but it may have a role in sharing information collectively with the profession through its SOMEp publications.’

Medical and Dental Defence Union of Scotland’s view is that ‘...initial learning from a fatal incident is most effective when undertaken independently of the regulator, as the
involvement of the regulator, particularly in the current climate, is liable to leave doctors feeling threatened and constrained, thus reducing the benefit of the process. In terms of disseminating learning from an incident more widely, there are already certain mechanisms for this, such as initiatives run by NHS Improvement. We would suggest that more could be done in terms of regional and national data collection and sharing in order to promote patient safety. The GMC does, of course, have a remit in ensuring the effective training and education of the profession and this should involve an element of learning from case studies.’

Scope of sharing

The majority feel that sharing should be on a national scale but there is also a substantial number that feel that it should be done on a local level.

Some state that it should be shared with ‘all systems where such cases can occur.’ Some others raised some cautions:

- ‘people want someone to blame and I fear that sharing learning in many people’s eyes would entail identifying who is at fault.’
- ‘Publicly, transparently and with full disclosure to ensure that the public are aware of the pressures that staff work under.’
- ‘politicians and the media should have seriously restricted access’
- ‘No place for the media in this’

Reporting systems

The BMA also highlight the various mechanisms for reporting incidents and say that ‘...many barriers exist to high quality incident reporting, linked to failures of software, onerous reporting systems and cultures that inhibit reporting. More must be done to encourage the use of not only incident reporting systems to raise concerns regarding patient safety but also to promote mechanisms such as exception reporting and monitoring, to prevent issues occurring where working conditions may well be compromised or induction or appropriate training to perform duties is not provided. Alongside this we need to streamline the process for providing such reports. Fundamental to any reporting system is the belief that healthcare professionals will not be targeted for their reporting, and in fact encouraged to highlight where problems occur so they can be acted on. It is essential to create a culture of reporting concerns. Allowing action to address systems where issues around support, supervision or unsafe working exist.’

Alternative mechanisms of sharing

- Email bulletins
- Email cascaded down via Medical Directors.
- Newsletter ‘a newsletter for all miss and near miss incidents, irrespective of the outcome.’ We are told that MPS ‘send out an annual ‘newsletter / booklet’ which usually contained a brief report of cases that had occurred with the outcome... this is both interesting and informative.
- Grand rounds
- Courses
- Public reports
- Publish results
- Clinical meetings
- Mortality meetings
- Speciality associations’ publications.
- Case reports/reviews-learning
- Meetings
- Small meetings with colleagues and superiors

‘a meeting with family members present (if they wish to be). This should be regulated.’

- Medical press
- Peer review
- Open data base
- Anonymised case vignette
- An anonymised register of fatal incidents, the outcome and key learning points
- Mandatory training
- Alerts e.g. equipment and medication as per MHRA
- Local M&M meetings
- podcast
- Seminars
- A national searchable database of all regulation 28s from Coroners inquests.
- a national conference ‘where the cases are discussed and learning can be disseminated. Create a positive culture for Learning rather than current culture of fear.’
- a national alert system ‘which the regulator could set up and maintain, to advise doctors - and their organisations - of learning points from fatal incidents, and corrective actions to be taken. It then becomes a moot point whether these corrective actions are suggestions or mandatory.’
- ‘needs to line up with other high importance alerts like alerts ‘potential for hospital generators to explode and short shelf life on cytotoxics’
- ‘existing processes such as NPSA alerts’
• Registers could be kept that could be searched like PubMed and systems for pattern spotting could be implemented

• Legally privileged web or cloud-based platform. There should be regulation about Trusts responsibilities to review the site and action learning - perhaps this needs to be done through nationally managed safety alerts and actions.

• Responsible reporting in the press.

• Incrementally ‘internally within department and then trust / then if appropriate, across similar services’

Who should share the information?

There were a number of recommendations made as to who should disseminate learning following fatal incidents, including:

• Defence Orgs
• GMC - One asks if the GMC could hold conferences for this purpose; ‘GMC online, so everybody can learn’
• Local department meetings so that its relevant to area of medicine
• NHS
• Department of Health
• Those involved in incidents, via presentation
• Medical Royal Colleges Teaching sessions via
• Written report by impartial investigator
• Health minister- one respondent comments that ‘DH and politicians aren’t held accountable for anything’
• HEE and the deanery to support this
• Royal colleges- one respondent comments that ‘they have been in dereliction of their duty. For example they were aware of the unusually high death rate of children having heart surgery at Bristol and did nothing. They should have been aware of Patterson too, but were apparently not. Why not?’
• NICE - ‘NICE already have a system to do this in place’; ‘NICE and SIGN guidelines, Incorporated in NICE guidance’
• HSIB
• HSE should be involved in many more fatality/serious Mhs incidents than actually happens.
• a national body with predominately medical members to collate and research to look for systematic factors which are causing incidents – ‘NOT the CQC’
• National Patient Safety Agency ‘if it still has the resources to do so’
• Centralised body sharing info. Like mhra for medicines
• database of past errors and dangerous scenarios ‘would help - so long as it is well collated, succinct, and readily available’

Anonymous or not
Some say that the information shared should be anonymised so that it’s not used against anyone and so that most learning can be made. The word ‘anonymised’ was used 20 times in online submissions.

‘Anonymise both staff and patients’

Learning from positive events
‘There needs to be a complete overhaul of the incident reporting system which still focuses too much on what goes wrong, and on who is to blame. Positive incidents, where things go exceptionally well, need to be equally reported and lessons learned shared on how to successfully do things right/prevent things going wrong.’

Issues
• ‘sharing must be relevant and in brief bullet points that can be easily read. a 10 page document attached to one of 25 emails a day will not be read’
• ‘The profession itself should have full ownership of the process’
• ‘Encourage small local meetings where attendees can feel able to express opinions’
• ‘Concise summary with practical tips on how to avoid error / link to learning resources.’
• ‘400 emails from JRCTB, GMC, royal colleague, ABN, trust etc are overwhelming and get deleted.’
• ‘Email bulletins are hopeless as we all get too many emails’
• ‘Avoid widespread e-learning, mandated figures for learning on an issue.’

Approaches to emulate / already doing
Aviation approach mentioned a few times – ‘open no-fault system such as airline industry’.

‘Published bulletins that include all incidents not just fatalities.’

‘PPO does this well with death in custody lessons learned’37

‘A Human Factors system, similar to the airline or oil industries, needs to be embraced, rolled out and adequately funded. There needs to be a greater effort to eliminate blame culture and bullying from the NHS - including making management staff fully accountable for their actions, in a way similar to clinicians. These issues have been extensively laid out by Lord Franci’s report on Mid Staffordshire Hospitals.’

‘In obstetrics we publish a three yearly review of all maternal deaths. Other specialities should do the same.’

'Maternal deaths and near misses enquiry modal seems to work well, yes a central coordination and dissemination of very short (no more than 1*A4 per year- otherwise it will not be read) summary of findings that people can look up more information if needed later.'

'A previous trust would put 3 cases a month on intranet from various specialities so anyone could see lessons learnt - I thought this was a good idea.'

'Healthcare Improvement Scotland (HIS) has agreed with the Procurator Fiscal to share the learning points from particular reviews into deaths more widely across NHSScotland, in order to facilitate national learning and improvement. The aim of this process is to ensure that learning from death investigations is shared in the most efficient and effective way possible, and ensuring that this is done in collaboration with the NHS board in which the review took place.'

**Law Society of Scotland**

When a death occurs, lessons where possible should be learnt. Extending the criminal law to take an increased role in regulating healthcare may not be the best means to share learning from a fatal incident. We would endorse the view that "the adversarial nature of the criminal trial does not lend itself to the task of identifying what lessons can be learnt from a tragic and unexpected medical death." Any death as required by Article 2 of the ECHR should be fully investigated. That holds good no matter the process whether in Scotland or otherwise.

We have set out the roles of the various organisations throughout our responses which include COPFS and the GMC. They do not overlap in their respective remits. The regulator should tend only have a role when the other processes have been concluded whether in relation to COPFS in decisions as to prosecution or the holding of a public inquiry. The problem if the regulator acts earlier is that the other decisions such as criminal prosecution (highly likely) or a FAI (less likely) could be prejudiced. In practice the regulator tends to wait though of course interim suspension of a practising certificate could take place pending a full hearing.

We have identified the regulatory role already which is in relation to regulation of conduct of the medical profession. That does not and should not trespass on the jurisdiction of the prosecution service or the Lord Advocate in relation to the holding or remit of any public inquiry.

- If the death results from criminal conduct subject to the relevant rules of evidence, prosecution can be affected if and only if it is justified in the public interest.
- If the death raises issues of public concern, then a FAI can be held.

38 Please see the following link for the process: [http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4089731/0d5b7acc-189f-410f-96c9-3cb6cde4a444.pdf](http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4089731/0d5b7acc-189f-410f-96c9-3cb6cde4a444.pdf)
• If neither of these apply, it is open to the GMC to conduct proceedings.

What does seem important is to ensure that these processes once concluded all feed into a mechanism for improving medical training or hospital procedures where relevant. That indeed is part of the purpose in the determinations issued by sheriffs and the process for recording them under the 2016 Act.

What is also clear is that the public must be able to find out what has happened so transparency of process is also crucial. That may be a further factor for the Review to consider. To be judged by the media is not the best place for any of the parties who may be involved. There are suggestions indeed that any apparent increase in GNM prosecutions has come about from ‘media content [which] is of course highly selective driven by consumer, social, political and economic interest.40 Ensuring public understanding seems to be a benefit of the public scrutiny being undertaken as part of the Review.

**Patient or family member of a patient (6 responses)**

- ‘GMC should have role / needs to justify and explain decisions/actions / Duty to help prevent further incidents /
- ‘centralised body sharing like MHRA for medicines’
- ‘GMC yes / health and safety executive should be involved early on / HSE should be more involved in serious incidents’
- ‘share with public’
- ‘Yes / action plan drawn up monitored by CQC and Health improvement’
- ‘presentation by chief med officer, DON’

**Question 52. Do you have any other points that you wish the review to take into account that are not covered in the questions before?**

There were 384 responses to this question online.

The themes in the responses online were reflected in general comments made in offline submissions as well. The vast majority of themes in response to this question reiterated those made throughout the questionnaire. In particular the themes relating to the Dr Bawa-Garba case and the GMC – the acronym ‘GMC’ is mentioned 177 times in online responses and the name ‘Bawa’-‘Garba’, 37 times.

Many respondents helpfully suggested their willingness to contribute or discuss their submission with the review working group if it would assist.

**Patient or family member of a patient (12 online responses + 3 offline)**

We are reminded by one patient or family member to…‘remember [the] position of family/next of kin. Whatever process is put in place needs to be understandable and accessible. Similarly, another respondent highlights that …‘consideration first and foremost must be given to the patients, and the victims whom have been harmed or lost their life.’
Another adds that ‘the GMC should involve patient’s families at a very early stage and should contact them directly regarding the death of their relative.’

There was a recurrent theme amongst this respondent group that ‘...the current regulatory systems are too lenient.’ Another shared their view that the ‘...current systems [are] not fit for purpose, need radical overhaul’, and that there is ‘...no adequate accountability from top down.’

One says that ‘...the regulatory bodies should also hold permanent records of doctors whose severe negligence cause death to a patient it does not have to make that information public but it must be able to track doctors from trust to trust and the serious mistakes they make. It should consider past incidents when dealing with any future serious incidents involving them.’ Again, along a similar vein...‘doctors should not be immune from carrying with them their mistakes, at least for a set period of time.’ One family member adds that ‘...An attempt by the medical profession, the GMC and or other bodies to water down criminal act that have been carried out by the medical profession is unacceptable and needs to be brought to light by pressure groups and the media.’ One highlights their belief ‘...that the state has a responsibility, duty, to investigate each and every death that has occurred due to the ‘state’.’

One family member calls for an urgent review of end of life care deaths in hospitals following the Gosport investigation findings and end their submission with reference to a quote by an Irish Judge (Sir James Charles Matthew), saying it is as relevant today as it was in the 19th century ‘...In England justice is open to all – just like the Ritz.’ Similarly two other family members tells us about their experiences following the death of their family member and views on the Liverpool care pathway and one says ‘...one day I know the equivalent of the Hillsborough families justice case will happen and those cases wrongfully killed off by criminal doctors will be heard.’

Another adds ‘we do not believe a few months suspension benefits the doctor, or the public in anyway,’ although it should be noted that this respondent doesn’t say what would be preferable or whether they thought it was because they felt it was insufficient to protect the public or the reverse.

Contrary to the opinion that the systems in place are too lenient, another says that ‘...trusts should be discouraged from rejecting a doctor for a post due to a serious error being recorded and should ensure that the doctor is given more support in that area.’ Similarly another says that ...‘The GMC should support staff in retraining in areas that they have fallen seriously below the standard acceptable. They should track their progress closely. It should also consider carefully the seniority of the doctor responsible for the death and consider if it is appropriate for the doctor to remain at that level after causing the death of a patient due to gross negligence.’

One patient or family member says ‘...Most of the healthcare I have received has been outstanding but the times that I have received poor care, the main motivation for me was to help the team learn from the event and avoid the same experience happening to someone else. However, I have found it difficult to be heard, my concerns dismissed by healthcare professionals and a culture of being quiet perpetuated. The enormous majority
of healthcare workers are kind, compassionate, hard working professionals who strive to do their best under challenging circumstances. The system needs to support patients to speak up and workers to learn. This can only be done by creating a supportive environment that focusses on the patient experience and actively works to address the organisational failures that make the every day life of the NHS worker harder.’

One family member argues that the ‘...GMC shouldn’t be above the law/GMC should be prosecuted and compensate for harm done to doctors’ but doesn’t provide more comment than that.’

Another family member or patient calls on the review to ‘...consider the structure of Police forces in England. There are 42 police forces and if one of them makes error of judgment there is an independent investigation by another police force in the country. There are also investigations carried out nationwide by the IPCC into complaints against police officers in general. I would strongly suggest that the NHS should adopt a similar procedure.’ There was also another family member who suggests ‘...getting police from neighbouring forces to interject.’

A healthcare professional gave us some feedback based on their experience as a patient ‘...Most of the healthcare I have received has been outstanding but the times that I have received poor care, the main motivation for me was to help the team learn from the event and avoid the same experience happening to someone else. However, I have found it difficult to be heard, my concerns dismissed by healthcare professionals and a culture of being quiet perpetuated. The enormous majority of healthcare workers are kind, compassionate, hard working professionals who strive to do their best under challenging circumstances. The system needs to support patients to speak up and workers to learn. This can only be done by creating a supportive environment that focusses on the patient experience and actively works to address the organisational failures that make the everyday life of the NHS worker harder.’

One respondent who selected ‘other’ as the category, lists the following three areas that they wish the review to take account of:

1. "The Nurses' Station“- I really do think that a maximum number of people (nurses, doctors, HCAs) should be allowed around the nurses station on any ward at any one time. This affects many many wards. I regularly visit friends in hospital where a noisy party seems to be in full swing at the nurses' station , but no medic (Dr or nurse) is present near the patients during the whole time that I am there . Are they watching over sick people or organising a Dating agency?

2. Management/admin in hospitals- there can be no excuses for poor IT, poor tele comms systems, filthy wards and toilets

3. There are "pinch points" in the year (Don't be ill in the first week in August or any Bank Holiday). High time to do something responsible about this.’

MENCAP advocate that what they want to see in future is:

• ‘a system that upholds strong principles of accountability when serious mistakes are made, and recognises that failure to provide adequate care and make reasonable adjustments for people with a learning disability is simply not acceptable. It must be
recognised that the death of a person with a learning disability due to delays in care or failures in treatment is utterly unacceptable.

- Both the systems and individual clinicians implicated in a death must be subject to rigorous investigation, and appropriate changes made to systems and practice, as well as appropriate sanctions in the case of clinical failures.
- We would like this review to consider the levels of gravity placed on the deaths of people with a learning disability and how that impacts on decisions about their care.
- a system with expertise in learning disability which can provide the care that people need and recognise where something has gone wrong. Mencap asks this review look at the levels of expertise involved in decision making during the investigations process and how this impacts on the decisions that are made about whether or not the care people receive is appropriate.
- a system that is able to differentiate between the actions of individuals and systematic failures and address both. Often the stories we hear are a mixture of failures of individual healthcare professionals and institutional failures.
- a system that supports families through the investigation process.
- a system where genuine learning occurs to prevent these things happening again and where professionals are appropriately accountable for their actions.’

Feedback from medical professionals (258 of the online responses); professional representative or membership organisation, college or trade union (13 responses); Other healthcare professional (3 responses); and Legal profession (2 responses)

The majority of these responses centred around the significant pressures on practising doctors and the blame culture and climate of fear in which they say they work. Many say they feel like they could make, or have made, the same or similar errors as Dr Bawa-Garba and therefore feel as though they could be prosecuted for GNM as well.

One respondent argues that ‘...We cannot put cases like Dr Ubani\(^41\) (and the organisation who hired him) in the same box as Dr Bawa-Garba. The former made a tragic error through lack of knowledge of the local systems and formularies; he should not have been allowed to work in the UK without an induction course. The latter was the right person (BME trainee) at the right place at the wrong time. Dr Bawa-Garba has my full sympathy; Dr Ubani does not. To cluster them both under culpable homicide feels wrong.’

Many also highlighted problems with the application of the law of GNM in the medical setting. A number of respondents argue against the criminalisation of medical error/genuine

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\(^{41}\) A doctor convicted in Germany of GNM for the care of a patient in England. A Guardian article on this can be seen here [https://www.theguardian.com/society/2010/feb/04/doctor-daniel-ubani-unlawfully-killed-patient](https://www.theguardian.com/society/2010/feb/04/doctor-daniel-ubani-unlawfully-killed-patient)
mistake, saying that the law needs reform, and highlight the unique context in which they work.

Unique context of medical practice in relation to GNM and perceived heightened vulnerability for particular areas of practice

The following extracts describe the nature of this perceived, unique vulnerability of the medical profession to GNM investigations and the complexities associated with application of the law in this area:

- ‘Although no one is above the law, the nature of our profession, where every act from a prescription to a diagnosis or mis-diagnosis, to a minor or major invasive procedure inflicts actual or potential harm to an individual is very different. We are tasked with doing potentially dangerous & fatal things to members of the public on a daily basis, as an integral part of our professional roles unlike any other profession & this must be legally recognised. We incise, operate, insert and inject but then suddenly we are deemed to be assaulting and inflicting grievous harm - but only when it suits...’

- ‘Medicine is mostly ‘statistics’ and ‘likelihood’ not certainty, which the public mostly does not understand, and most of medicine is about balancing completing risks and likelihoods, with insufficient information to do this well.’

- ‘When a patient has a lethal, but potentially curable illness, and the patient dies, it can be very difficult or even impossible to determine with any degree of certainty whether a delay in starting treatment influenced survival... in an over stretched NHS whether treatment is started in a timely manner depends on organisational factors and chance, such as whether a patient is admitted at a time when the unit is well staffed and there are no other sick patients waiting to be seen, or whether the unit is understaffed with a large number of sick patients in the queue... the situation is complicated when there are a series of errors by a number of staff in a hospital or clinic and “blame” is attached to the errors of one or two members of staff, when it is a matter of opinion which individuals and which errors were most likely to be so serious that they can be considered to have contributed to death. In addition, errors of commission are more likely to be viewed as responsible for a death, when errors of omission may be more serious. For example, a junior doctor may make some error in active treatment of a patient. The responsible consultant knows what the junior has done, but takes no action to correct it. The junior doctor will be blamed, but in that scenario, the consultant should bear a greater responsibility because of his or her greater knowledge and experience.

- Dr Jenny Vaughan tells us that ‘...A jury in 2013 found Sellu guilty of a criminal offence, yet an MPTS panel in 2018 found no misconduct against him in the same case. This area of law has always been controversial. Either it needs to be removed, or strict guidelines should be applied in its use. This case shows medical GNM should not be used in complex cases with multiple co-morbidities, many participants, complex pharmacology or significant systemic failures. There is also widespread concern that this law has been used in cases like that of Hadiza Bawa-Garba, where there was a clear back-drop of inadequate patient monitoring, senior support, and IT failure.

A number of medical professionals that there are unique factors of particular specialties or areas of practice in which they believe there is a greater risk of being investigated for GNM, for example, those in which the risk of patient death is higher, there is more litigation in their area, patient and family expectations are higher or pressures from them are more acute, and/or those in which the context of their practice makes it more likely that they will be blamed as individuals. For example the Royal College of Obstetrics and Gynaecology highlight that:
• ‘...obstetrics is a particularly high-risk specialty and it is highly likely that most obstetricians will be involved in the care of women and babies with adverse outcomes at some point in their careers. Clinicians, therefore, need to be clear about the purpose and impact of all investigation processes and how and where gross negligence manslaughter and culpable homicide are considered in relation to medical error. Equally clinicians need to be provided with clear guidance on what is expected of them and of the organisations that they work for when a process has been started for a suspected GNM charge. Obstetrics is also a high-litigation specialty and there are several investigation processes and routes already in place for addressing medical error in maternity care. It is critical that employers and individual clinicians working in obstetrics are clear about the circumstances and, importantly, the process in which a serious incident may be escalated into a charge of GNM.’

Faculty of Pharmaceutical Medicine argue that:

• ‘Errors in prescribing are central in the issue of GNM&CH*. They currently account for many if not most of the GNM&CH cases reported Crown Prosecution Service (CPS) and those that go to court*. Whilst the first two recorded cases were medicine related, (morphine overdose) there was a marked difference between the 19th and 20th centuries. The 19th century was characterised by obstetric deaths whilst in the 20th century it has been related to use of medicines. The problem of errors of prescribing is endemic in healthcare systems around the world. It has been recently reported that 66 million potentially clinically significant errors in prescribing occur per year in the NHS.* Prescribing errors account for an estimated 22,000 deaths per annum in the UK. Prescribing errors are the third most common cause of avoidable death in the USA. Prescribing errors are increasing and implementation of effective remedies is not occurring...We draw a link between to rising number of prescribing errors and the decline in professional training in Clinical Pharmacology.’

Feedback and criticism about the GMC

A great number of doctors reiterate their distrust in the GMC, its fitness for purpose, and how the GMC needs to improve its’ approach, reflect/learn from mistakes and rebuild trust.

Royal College of Psychiatrists Scotland say that ‘...The structures of the GMC have changed dramatically over the past ten years, and the scope of its work and remit has broadened, including postgraduate medical education and revalidation. We would like to see greater balance in the GMC to consist of more members from the medical profession, and consideration of the return to elected representation. The GMC must recognise that there is a need to restore its authority with medical professionals. There needs to be a reengagement with the medical profession. There is also more work to do within the structures of the GMC to respond to the challenges of devolution with consideration of devolved councils being established in Wales, Northern Ireland and Scotland.’

Doctors’ Association UK say that ‘...in recent years the GMC has been seemingly weaponised. Referral to the GMC in a malicious way is being seen as a way of preventing doctors speaking out or whistle blowing about injustices. In the case of Prof Edwin Jesudason, a whistle blower from Alder Hey. Hospital, threats from senior clinicians about referring him to the GMC suggested the need for a malicious referral to prevent whistle blowing. Furthermore, emails detailing the suggestion that a prominent doctor and medical journalist could be referred sought to limit the actions of the free press. In such a way, weaponising the GMC’s referral process can be used against doctors with malicious intent.'
The GMC must look to find a solution to this problem where threats of referral or actual referrals are leading to a situation where patient safety concerns are silenced.’

Hospital Consultants and Specialists Association argue that...‘in considering the balance between public confidence and maintaining proper professional standards, the GMC should be placing the greatest emphasis on the latter. The MPTS should be allowed unhindered to consider the fitness to practise of an individual, and should be able to do so in an unprejudiced way. Public confidence can be maintained by the GMC clearly and publicly promoting its belief in the robustness of the MPTS process. Doing so may at times place the GMC in a position of conflict with the press etc, but for the most part the rationale for not striking an individual off can be clearly explained and articulated to the extent it would satisfy the bulk of the public, even if not every single member of the public nor those journalists seeking sensationalist headlines. By adopting such a fair and reasoned approach, the GMC would take an important step towards rebuilding bridges with the medical profession.’

The Royal College of Paediatrics and Child Health reflected a number of the concerns raised by medical professionals and the representative organisations above generally, agreeing that the GMC’ decision to appeal the MPTS has ‘created a broad and deep groundswell of disquiet amongst the profession’ and that GMC’s relationship with the profession is at a ‘low ebb’. They also say though that ‘medical manslaughter cases are only one among several issues that have undermined the profession’s confidence in the GMC.’ However, they commented that they are keen to move to a situation where the GMC regulates with the support of doctors.

Royal College of Obstetricians and Gynaecologists told us that...‘since the judgement the RCOG has been actively engaging with its members, particularly its trainees, to explore the issues and to support clinicians to regain the confidence with reflective practice and the regulator, which some have expressed has been lost. The RCOG is aware that social media has been a primary source of information for many, again particularly trainees. In response the President of the RCOG has met specifically with the RCOG Trainees’ Committee on this matter, to direct and encourage them to access the publicly available information and guidance. The RCOG is providing regular updates in response to the developing external landscape on the issues that have been raised and it has communicated the scope of this review with its members, highlighting the opportunity for individuals to comment.’

The BMA ‘...strongly recommend early active intervention based on concrete and anonymised historical data sources. The Regional Liaison Service at the GMC should be more widely advertised to ensure doctors are aware of the availability of this service, as a support mechanism.’

Some of the following extracts of comments demonstrate the strength of opinions expressed in the responses from the medical profession about the GMC:

- ‘NOT to receive information that the GMC is investigating you on a Saturday morning when you can not have support. SPEED up investigations.’
- ‘Please could the GMC acknowledge that the vast majority of doctors are dedicated, hardworking and keep trying to maintain their professionalism in the face of overwhelming and relentless pressures. The review needs to confront the issues of safe staffing,’
exhaustion and burnout and the desperately sad cases of doctors committing suicide when they just cannot cope anymore.’

- On average, a doctor can expect to face a GMC complaint one in his/her lifetime. (And a single complaint can easily take over one's life for months, even if it's not that serious, and even if the clinician is found not guilty at the end, or if the case is dropped.) Given that the majority of us don't end up with multiple complaints, this rather suggests that many of the existing complaints are more random than anything else. Therefore, should the GMC be raising the bar for complaints to rule out a lot of them, and enable it to concentrate on those things that really do seem to be beyond the pale and evidence of a deeper, more continuing incompetence?

- ‘I think the independence of this review has been completely undermined by the chair’s recent appointment to the GMC. Were an independent witness in an enquiry found to have been applying for a job in the department under investigation during the enquiry, it would undermine the entire process and they would potentially face a gmc investigation for failing to declare their conflict of interest as soon as it became apparent. I think this reflects the perception that doctors are held to much higher standards than the GMC adheres to itself.’

- ‘The HSIB should be leading this review, they have the expertise and understanding required the GMC do not’

- ‘I think people who have no clue about how doctors work (eg Charlie Massey) should have no place in the GMC. I do not think there should be political appointments.’

- ‘GMC should promote better public understanding re sensationalist media...drs are vilified’

A member of the legal professional says that... ‘the recent GMC cases reveal the difficult tension that exists in the regulator's role in ensuring public confidence in the profession which is often seen as requiring severe sanctions upon doctors despite their remediability or remediation. It is a difficult balance, but the public's faith in the profession would ultimately perhaps be better served by the encouragement of the duty of candour and learning from errors as opposed to the severe sanctions upon doctors who made bad but genuine ‘mistakes’.’

A respondent under category ‘other’ says that ‘...the GMC should make all fatal incidents public.’

One respondent queries ‘...With training and revalidation in place, its concerning that GNM happens - is it due to poor training or supervision? Are doctors consciously practising outside of bounds of competence? Is training too restrictive? Specialising too soon leaving doctors less able to deal with comorbidity?’

Queen's University Belfast tell us that they would like to see the review report consider the role of medical educators and students. Specifically:

a. What guidance should we give students in preparing reflective notes - both as students and as future doctors in their e-portfolios? Our concern is that students have become wary of identifying within their written work any deficiencies in practice that they have witnessed with the result that their entries become bland and the process of reflection is negated. We understand that in the Bawa-Garba case, reflective notes were not considered as evidence - but we know that they can be. How should we adequately prepare students for their future practice?

b. What specific legal issues should be contained within a medical school curriculum in relation to gross negligence, manslaughter and culpable homicide? Should it be covered, given that it is (thankfully) a rare event? Is there specific legal aspects of the law within Northern Ireland that we should make students aware of?’
In relation to the GMC’s handling of the Dr Bawa-Garba case more specifically medical professionals say:

- Dr Jenny Vaughan advises that... There have been serious concerns about the role of the General Medical Council (GMC) in the recent Bawa-Garba case and her erasure. Both Sellu and Bawa-Garba are black and minority ethnic (BME) doctors who gained their medical degrees from UK medical schools. All of us should be concerned that BME healthcare professionals might be being disproportionately brought before the courts and regulators for investigation. I make no allegations of racism; however, it seems to me that we need to urgently investigate this issue before more charging decisions are made.

- 'Please compare the GMC response to Bawa Garba and Barton (Gosport), they had two opportunities to limit Barton’s practice and they did not. It will be interesting to reflect on these two high profile cases - the characteristics of the Drs, the characteristics of the patients and the difference in response and outcomes.’

- 'Unimpressed by GMC’s failure to evidence public opinion.’

- 'CEO didn't need to go against MPTS. Jury didn't pass sentence the judge did and he also didn't have evidence of public opinion.

- 'MPTS is not judiciary it determines ftp [fitness to practise] and they determined that she is fit.’

- 'GMC vindictive and harmful to profession, CEO and Chair need to reflect on their position.’

- 'urgent action is needed, including the GMC setting an example of "honest reflection", which up to know I think has only been partial.’

- 'I think many of the doctors who fill in this survey will be motivated to do so by strong feelings within the entire profession, and particularly among trainees, about the case of Dr Bawa Garba. No doubt it is that case that led to the existence of the review. Most of my peers consider that she was treated appallingly, from being put in an impossible situation in the first place, failed by the system and then publicly vilified before being left to take the blame for the entire disastrous imbroglio alone, whilst the senior clinicians and managers who should have averted the situation in the first place got away scot free. To be further victimised by the GMC in turning over the result of the tribunal that was set up as an independent body to avoid such eventualities, only added insult to injury not just to her, but to the entire profession. Having followed that case avidly from the outset, the only thing I have ever been able to conclude with any certainty is that if it was me in her shoes that disastrous day, it is quite likely that more than one child could have died. Whilst this perception of the situation continues, it leaves a great number of good doctors appalled, dispirited and scared, knowing that there, but by the grace of God, go we.’

- 'The GMC will restore its credibility among doctors and the public by recognising the staffing issues in the Dr Bawa Garba case and either the trust’s responsibility for corporate manslaughter through understaffing OR recognising this is a nationwide issue because we cannot afford, train, recruit and retain nurses and doctors (which is a political issue and not necessarily anyone’s fault).’

In relation to views expressed about the case more widely (not focussing on the GMC in particular) we were told:

- 'The outcome in the Bawa-Garba case is absolutely disgraceful and the country should be profoundly ashamed for a witch hunt approach to an individual doctor who could not have reasonably been expected to perform any better within a dangerous system she was not empowered to change. Shame on the government and shame on the law.’

- 'Dr Bawa-Garba's case would not have led to a conviction and headlines if:
  i. she had not interrupted the resuscitation - this led the medical experts and coroner to consider she had acted exceptionally badly and refer her to the CPS. In fact, all agreed
at criminal trial that this interruption of resuscitation had no role in Jack's death. As the
criminal trial expert for the defence, I agree.

ii. she was white and English.’

Another doctor summarises their view:

‘Fundamentally we must remember that this case is about Jack, not his doctor. If we wish
to honour Jack’s legacy, the healthcare system must acknowledge that we failed him and
his family. As a service we must seek their forgiveness. We must seek to persuade them of
our determination to use the learning from the way we collectively failed Jack to make
things safer in the future. We should seek to engage Jack’s parents in this process if they
are willing. If the system can show itself to be facing up to its fault in Jack’s case, with safer
care for other children the outcome, then Jack’s family may be assisted in their grief by
seeing that, more than the punishment of an individual can achieve, his legacy is a
remarkable and dramatic force for good.’

The Scottish Independent Hospitals Association shared their view that Dr Bawa-Garba
...‘was in a difficult position.’ And they argue that the following factors should be in place for
all junior doctors:

a. ‘doctors returning from long absence must be re-orientated and supernumerary until signed
off
b. workload must be commensurate with experience
c. consultants must be available at all times to advise and support
d. human factors must be weighted in the final outcome.’

In relation to the state of the law of GNM in the medical context and practical application of
it, the following responses demonstrate (again) the strength of views in this area:

- ‘I am furiously angry at the whole nonsense of prosecuting doctors. Prosecutions are for
people who set out to do bad things e.g. rape, burglary, theft, ABH, GBH etc, not doctors
who go to work in a broken system and do their best to make it work. They make mistakes
because they are human. If they are bad doctors, stop them being doctors - don’t send them
to jail. Oh, and get used to the idea there are bad doctors out there. 50% are below
average. Where is the cut off, 2 standard deviations, 3? So train them better and continue to
support and train them.

I have been a Consultant surgeon for nearly 19 years and have never been sued. Have I
made mistakes? Of course. Am I so good I will never find myself talking to the Police about
the death of a patient? Well we shall see how LUCKY I am. I spend my days in the NHS
doing one thing - protecting myself. Any sensible doctor does the same. We practice very
defensive medicine and that is VERY expensive. Why has the NHS run into a sand trap?
Defensive medicine. Remember, you get what you wish for!! Finally the best thing this
country could do is train less lawyers.’

- ‘To believe that Bawa-Garba is guilty is to believe the system is innocent.’

- ‘GNM a threat to medical profession deterring driving drs to retire early ‘mass exodus of
clinicians’

Given these concerns, and the possibility of ending up in court if I do make a mistake, I can't
see me remaining in clinical practice for much longer.

- ‘Mistakes will always happen...families need help understanding the difference between a
mistake and GNM...NHS collapsing...DH ultimately responsible’

- We must have a healthcare system, a regulatory system and a judicial system that protect
us all, are not contradictory and value the valiant efforts to look after patients.

- ‘Deficiencies’ in Law
• ‘I recognise that this review is not trying to change the law, but the terms under which a clinician can be a) accused and b) convicted of manslaughter need to reflect what the criminal act actually is.’
• ‘Should be law stopping patients naming drs until case is heard’
• ‘If you are assessing a doctors actions against the test of gross negligence manslaughter then the best jury to judge that is a jury of peers - for junior doctors a jury of junior doctors, for consultants a jury of consultants in that specialty. I understand there is a fear in the public that it would be mates clearing mates but I do not think that would be the case. Doctors are protective of the integrity of their profession. You might find one or two that would try to protect their own but not twelve good (wo)men and true.’
• ‘Criminal law does not suit clinical cases well’
• The Royal College of Radiologists argue that... ‘Errors should not be viewed as a crime in the same framework of the criminal justice systems. The view of an error as a single standalone event which is entirely down to one person is simplistic at best in the increasingly complex medical systems we work in. If the type and magnitude of errors is not fully codified and left open to the interpretation of others, or seen to be at the whim of the press and societal disapproval, then the “no blame culture” (such as it is) will be lost and essential learning will not take place. Also, marginalised doctors will be at the mercy of colleagues who will cry wolf on them with no route for reciprocal reproach.’
• Hospital Consultants & Specialists Association say that... ‘HCSA does not believe that the use of the phrase “truly, exceptionally bad” and indeed the current crime of GNM are fit for purpose within the clinical setting.’

The BMA say in relation to the role of the jury:

‘GNM cases in healthcare are multi factorial and very complex. Juries are highly likely to find it difficult to get a clear grasp of all the circumstances given a lack of personal experience of working in healthcare and a potential lack of understanding of system pressures. It is therefore important that the jury is clearly guided as to whether such negligence was ‘gross’. Judges will direct the jury as to what this means. The judge will explain that the jury must “be sure” of the defendant’s guilt. Additionally, such complex cases leave a lay jury very dependent on the statements of the expert witnesses, who are expected to give their informed opinion of the facts. It is well known that there can be considerable variation in the quality of their evidence, yet the jury must decide largely on the basis of the performance of the expert in court given their own potential lack of experience in healthcare. It is therefore crucial that the jury is well guided and supported in making these crucial decisions.’

The BMA go on to advise that ...‘Courts should also be allowed to hear evidence from expert witnesses, other than medical experts, on the effects of fatigue to clarify the effects of decision-fatigue and rushed (due to pressure of work, not negligent) decision-making.’

An Advanced Surgical Nurse Practitioner says:

‘I am a nurse, not a doctor, however, I feel that all professionals feel quite shocked and fearful of what could happen to them if they make an honest error or isolated bad judgment. We are human beings, humans learn by error. I am obviously not trying to underestimate the terrible effects of a fatal mistake or lapse in judgment but, I feel that in order for us to continue to work with care and dedication we should be looking at how we investigate incidents and how we actually demonstrate that we are learning from those
incidents...I am very au fait with the Martin Bromily video, just a routine operation. Those health professionals all returned to work and Mr Bromily said that he was glad they did so as they would be better practitioners for that experience. I know of one excellent doctor who made a mistake and now says they will never practice medicine. again because of the effect this has had on them. We can’t afford to lose more people.’

Another healthcare professional tells us that their trust ‘...has a group of surgeons, anaesthetists and myself who teach human factors sessions. In the courses we have taught our feedback has been positive in almost every single case. We receive comments about how enlightening the course has been and how they are going to examine their practice from now on.’ Another healthcare professional comments that ‘...Human Factor training won’t get rid of all errors but it may reduce the number and also, that awareness may be able to help others investigate in a more open way.’

Many medical professionals highlight the current healthcare system pressures, the challenging environment in which they work and the detrimental impact this is having on them (including their health) and their ability to not make ‘mistakes’ or practise without fear, saying:

- ‘NHS has been historically underfunded – Government need to take some responsibility for medical mistakes because they are creating the environment’
- ‘As a doctor I fear making an error every day. I spend much of my time second-guessing and worrying about my clinical decisions. I have nightmares about inadvertently causing patients harm. Often there are too many patients for one person to deal with and things get missed.’
- ‘It is vital in all this to remember that all healthcare workers are people too, not machines. Medicine is impossible to know completely; we all work under stress; almost all of us care hugely. But we can also be worn down by psychiatric problems - depression and anxiety; overwork; bipolar depression. Many healthcare workers are all too aware of the enormity of the healthcare work, and of their own potential failings and areas of potential weakness of knowledge; a surprising proportion don't have much self-confidence, and what self-confidence they do have can easily be shattered. (It's often the most conscientious and capable NHS workers who commit suicide -- and in the aftermath, so many close to them comment on what high-quality medicine they actually produced, and what huge demands they made upon themselves.)
- ‘Medicine is impossible to know completely; we all work under stress; almost all of us care hugely.’
- ‘Many healthcare workers are all too aware of the enormity of the healthcare work, and of their own potential failings and areas of potential weakness of knowledge; a surprising proportion don't have much self-confidence, and what self-confidence they do have can easily be shattered. (It's often the most conscientious and capable NHS workers who commit suicide - and in the aftermath, so many close to them comment on what high-quality medicine they actually produced, and what huge demands they made upon themselves.)’
• ‘Quite a lot of healthcare workers are bullied by their managers; some staff are simply victimised’

• ‘We need to ensure that at all times we (society) treat healthcare staff with humanity. That doesn't mean we condone improper or slack behaviour, but it does mean that our response as a society has to understand that any punishment or public shaming must be done with these background things in mind.’

• ‘Quite a lot of healthcare workers are bullied by their managers; some staff are simply victimised. Like everyone else we have family troubles to sort out, family sickness to cope with, times of lack of sleep, personal pain... all these stop us from being machine-like in our perfection! Therefore we need to ensure that at all times we (society) treat healthcare staff with humanity. That doesn't mean we condone improper or slack behaviour, but it does mean that our response as a society has to understand that any punishment or public shaming must be done with these background things in mind.’

• ‘NHS is failing’

• ‘Doctors do not usually practice in isolation.’

• An academic tells us that ‘...Underfunding in NHS is costing lives. Lack of staff is leading to errors and a culture of compensation. There needs to be better support for doctors.’

• ‘Perfection and a mistake free scenario are not achievable/ever increasing expectation from our public fuelled by lavish promises from politicians.’

• An ‘important factor in determining culpability is doctor patient ratio...needs to be recognised standard number of patient that a doctor can be responsible for (based on type of doctor and level).’

• ‘It is so important that clinicians aren’t blamed for the poor funding, staffing levels, lack of supervision, lack of resources in the NHS. This must be taken into account. After all clinicians are unable to “whistle blow” without the very real fear of being suspended , so they are in a invidious position.’

• ‘When I’ve been on well-staffed jobs with good culture amongst seniors (flattened hierarchy), mistakes are much less likely to happen.’

• ‘I think a system that depends on a doctor reporting that they feel unsafe and unsupported and then demands several different actions as part of the report is unrealistic. There should be a simple system available to all for this - for instance, using a clinical incident reporting system and reporting inadequate cover as a "near miss" should be enough. It should then be the trust’s responsibility to address the concerns.’

We are reminded by a medical student that they ‘...are under increasing stress and need to be reassured that they are not entering a profession where a genuine mistake could lead to imprisonment. As fewer move from foundation to core training this needs to be addressed.’
One respondent from the category ‘other’ told us that they ‘...Used to ‘adore’ working for NHS but politicians siphoned off money for research to get their ‘chair’ / having seen how whistle blowers treated, left.’

Some medical professionals stressed their view that there is a blame culture in the healthcare systems which encourages defensiveness or defensive practice. They say that needs to be changed to transparency, listening, learning, and ‘no-blame’ and that the ‘threat of litigation is an additional burden on the system’. They say that... ‘there is a choice of how we proceed - either a litigious system with a culture of fear and reluctance to share information or a culture of openness and learning that would require a degree of protection of clinical staff if they make a genuine mistake.’

We are repeatedly told that doctors are currently practising in a climate of fear. That they have ‘...lost [the] patient first mentality’ ‘practise defensive medicine,’ which is... ‘a waste of doctors’ time and NHS resources’... ‘They over-investigate and over-refer for fear of litigation. This is bad for the NHS.’ One medical professional gives the following example... ‘surgeons [are] now reluctant to take cases with higher risk...patients more likely to be denied option of surgery...leaving junior surgeons to operate on most complex and high risk patients’

Epilepsy CNS told us that... ‘If clinicians become criminally responsible for their errors then I fear for the future of healthcare, decisions will be made in the best interests of the clinicians career. Medical care is not and never will be free from risk, however the risks of defensive practice will lead to poorer outcomes for patients. There will be a reduction in reporting of incidents and potential for hiding evidence of poor practice if the threat of criminal proceedings exists.’

They say that ‘...consultants, supervisors need to be much more supportive [but] need to be given time and incentive to do this’. And they argue that ‘...Junior doctors in training need a level of protection which can only be given by a consultant or senior doctors presence during what can be fast moving clinical events’

Following on from the issues highlighted above in relation to the systems pressures doctors face, many medical professionals highlighted their perception that healthcare providers/organisations, boards and non-medical managers are not (visibly) held to account for their ‘system responsibility’ by regulators or the criminal justice system, saying:

- Epilepsy CNS say...Scapegoating is a concern as trusts try to distance themselves from blame and limit damage.
- ‘more emphasis on Trusts liability / trust should have been charged with manslaughter’/‘Regulation of senior managers and their role in manslaughter.’
- ‘Why is it always just doctors who are punished? Why are we the scapegoats? Start punishing people who run unsafe rotas’
- ‘The managers who implemented the systems in which failures happen should also be made to meet the families and patients affected so they can truly realise that they share responsibility for making things go well.’
‘key issue is Corporate manslaughter...other issue is corporate governance’

‘Politicians and civil service should be held accountable...Whistle blower don’t have enough protection’

‘I would like to know why the GMC is not regulating the managers that design and make decisions regarding human resource capacity, workload and rosters. Management decisions have an immense effect on experience of patients, quality of healthcare and safety. Managers (whether originally clinically trained or not) who design and are given the power to implement systems in which front line Drs and other clinical staff are put in difficult and dangerous situations should be held to account for the impact that their decisions have on patients and staff. If managers were held to account in these ways maybe we would have a safer better run healthcare system overall. The managers who implemented the systems in which failures happen should also be made to meet the families and patients affected so they can truly realise that they share responsibility for making things go well.’

The BMA say in relation to the role of management...‘NHS managers operate within a complex political environment. Further, managers are required to operate within a system which has in-built tensions. For example, funding of certain treatments or reconfiguration of services are areas where political requirements can conflict with pragmatic strategic management. The BMA however believes that managers have to take a proactive role to ensure that the clinician’s work is carried out in safe conditions.’

‘When over 1000 patients died in Stafford, no-one appeared before the criminal courts. When one death is attributed to a doctor, a manslaughter charge is brought. Stalin said that one death is a tragedy and one million deaths are a statistic. Why the difference? First reason. One involved managers. Four legs good, two legs better. Doctors are a convenient scapegoat for the deficiencies of the N.H.S. The analogy drawn between airline safety and medical care is specious. If one pilot is missing or some machinery is broken, the plane is cancelled. The hospital never closes in the face of staff shortage or poor equipment. The customers on a plane are nearly all healthy; the ones in hospital are nearly all ill. Second reason. Geography. If over 1000 patients had died in a hospital within the M25, would there have been criminal charges? I think so. A recent lamentable characteristic of adverse events is the commissioning of multiple different enquiries. The Williams enquiry has already made recommendations. This practice guarantees obfuscation and is clearly a desirable tool of government. A change in the law is vital. Confidence in the legal system will not be restored by manipulation of the current system. The terms of this enquiry exclude the solution.’

Whilst a couple of respondents suggested that the healthcare systems should copy the airline industry, there were a number of respondents who agreed with the above comment in regards to the analogy drawn with the airline industry being ‘specious’. They say:

‘Airline levels of safety do not apply: if there is not a co-pilot, the plane doesn't take off. For Dr. Bawa Garba the plane had already taken off.’
• ‘...If one pilot is missing or some machinery is broken, the plane is cancelled. The hospital never closes in the face of staff shortage or poor equipment. The customers on a plane are nearly all healthy; the ones in hospital are nearly all ill.’

**Other comments**

Other respondents advised:

- Epilepsy CNS say that ...Often there is a trial by press/social media with little of the actual evidence and the voice of the individual under investigation is often unheard whereby the voice of the victim and family is.
- Healthcare needs to learn from other professions
- ‘how well organisations support medical staff needs to be imbedded in the regulatory process’
- ‘A no fault system should be instituted like in NZ’
- ‘I think some lessons could be learnt from the Ombudsman’s techniques’
- ‘Read Black box thinking by Matthew Syed’
- ‘A national team to independently investigate deaths or at least a panel approach to independent experts would be an improvement as would a greater budget within Trusts to investigate internally.’
- Royal College of Physicians and Surgeons Glasgow... ‘Measures to consider the patient’s voice have been developed. However, we often hear the voice of the loudest patient, but not the most important voice to hear. The present patient complaint system has not improved services to enhance safety.’
- One notes that they find it worrying how little they know about the subject and that ‘...the is need for education’
- ‘Tribunal / court cases should be confidential. Social media hate campaigns are not helpful.’
- ‘Previous quality initiatives have been abandoned in the new ‘market’ NHS and reorganisation led to a loss of local accountability. Local organisational memory was lost and with it local investigation.’
- ‘Investigations should' be process based rather than outcome based. Much time is spent investigating situations where there has been an adverse outcome, but in which there was no error or problem. There is therefore little time to investigate the group of adverse events in which a problem occurred, the outcome turned out OK, but the potential for that problem to re-occur remains.
- There should be investigation on individual basis. It requires research and mind shift throughout system. Patient safety must be central.
Annex A: Full list of questions in the call for written evidence submissions

This section focuses on what you consider to be 'criminal acts' by doctors

41 What factors turn a mistake resulting in a death into a criminal act?

42 What factors turn that criminal act into manslaughter or culpable homicide?

This section focuses on the experience of patients and their families

43 Do the processes for local investigation give patients the explanations they need where there has been a serious clinical incident resulting in a patient’s death? If not, how might things be improved?

44 How is the patient’s family involved in the local trust/board/hospital investigation process and in feedback on the outcome of the investigation?

45 What is the system for giving patients’ families space for conversation and understanding following a fatal clinical incident? Should there be a role for mediation following a serious clinical incident?

46 How are families supported during the investigation process following a fatal incident?

47 How can we make sure that lessons are learned from investigations following serious clinical incidents?

This section focuses on processes leading up to a criminal investigation

48 Do you think that the current arrangements for reporting and investigating serious clinical incidents within healthcare settings are effective and fair? If not, what is wrong and how might they be improved?

49 Would there be benefits in ensuring a human factors assessment approach is used in local investigations as opposed to a root cause analysis? 'Human factors’ refer to the environmental, organisational and job factors, and human and individual characteristics which influence behaviour at work in a way which can affect health and safety. A ‘root cause’ analysis is a systematic process for identifying ‘root causes’ of problems or events and an approach for responding to them.

50 Typically, who is involved in conducting investigations following a serious clinical incident in hospital/trust/board or other healthcare settings and what training do they receive?

51 How is the competence and skill of those conducting the investigations assessed and assured?
52 In your hospital/trust/board or other healthcare setting, is there a standard process/protocol for conducting investigations following a serious clinical incident leading to a fatality? If so, please email a copy to ReviewofGNMandCH@gmc-uk.org.

53 What measures are taken to ensure the independence and objectivity of local investigations in hospital/trust/board or other healthcare settings?

54 What is the role of independent medical expert evidence in local investigations?

55 How are independent experts selected, instructed and their opinions used? Is access to appropriate expertise always available? Do they have training in unconscious bias?

56 Are there quality assurance processes for expert evidence at this stage, if so, what are they?

57 How can we make sure that lessons are learned from investigations following serious clinical incidents? (please respond here if you haven’t already responded to this question in the patients and families section)

58 What support is provided for doctors following a serious clinical incident that has resulted in the death of a patient (including emotional, educational, legal, professional support)? Could this be improved? If so, how?

59 How and when are decisions made to refer a fatality to the coroner, or in Scotland, to the police? Who does it? Who do you think should do it?

60 What evidence is there that some groups of doctors (by virtue of a protected characteristic) are more or less likely to be subject to investigations leading to charges of GNM/CH than other groups? What are the factors that may be driving a greater likelihood for certain cohorts of doctors to be subject to investigations leading to charges of GNM/CH?

61 Do you think there are barriers or impediments for some groups of doctors to report serious incidents and raise concerns? More specifically are there additional barriers for BME (black, minority and ethnic) doctors? If so, which groups are affected by this and how can those barriers be removed?

This section focuses on inquiries by a coroner or procurator fiscal

62 What is your knowledge or experience of cases involving clinical fatalities that have been referred to the police or procurator fiscal? What can we learn from the way those cases have been dealt with?

63 To what extent does an inquest or fatal accident inquiry process draw on or rely on the evidence gathered in the post incident investigation by the hospital/trust/board or other healthcare setting?
64 What is the role of independent medical expert evidence in inquest or fatal accident inquiry processes?

65 How are independent experts selected, instructed and their opinions used? Is access to appropriate expertise always available? Do they have training in unconscious bias?

66 Do the same standards and processes for experts apply regardless of whether they are providing their opinion for a local investigation, an inquest or fatal accident inquiry process? If not, why not? For example, is there a higher level or different type of expertise or skill set required?

67 Are there quality assurance processes for expert evidence at this stage, if so, what are they?

This section focuses on police investigations and decisions to prosecute

68 To what extent does the criminal investigation and/or prosecution process draw on or rely on the evidence gathered in the post incident investigation by the hospital/trust/board or other healthcare setting?

69 What is the charging standard applied by prosecuting authorities in cases of GNM/CH against medical practitioners? How does the charging standard weigh the competing public interest in improving patient safety?

70 Are there factors which potentially hamper key decision makers in making fully informed decisions at each stage of the process, 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?

71 Do the key decision makers (the police senior investigating officers (SIOS), and/or prosecuting authorities) have the necessary support to enable them to make fully informed decisions on whether or not to charge a doctor of GNM/CH? Is there a need for detailed prosecutorial guidance for this offence (similar to that for assisted suicide)?

72 Why do some tragic fatalities end in criminal prosecutions whilst others do not?

73 Under what circumstances would it be more appropriate to consider cases involving fatal clinical incidents within the regulatory system rather than the criminal system?

74 What is the role of independent medical expert evidence in criminal investigations and prosecutions?

75 How are independent experts selected, instructed and their opinions used? Is access to appropriate expertise always available? Do they have training in unconscious bias?

76 Do the same standards and processes for experts apply with regards to evidence provided for the police or prosecuting authorities as they do for a local investigation, an inquest or
fatal accident inquiry process? If not, why not? For example, is there a higher level or different type of expertise or skill set required?

77 Are there quality assurance processes for expert evidence at this stage, if so, what are they?

78 There was a low response rate to this question from all cohorts. None were aware of any QA processes used.

79 What lessons can we take from the system in Scotland (where law on ‘culpable homicide’ applies) about how fatal clinical incidents should be dealt with?

80 Medical Profession:

81 Most of the respondents felt they did not have enough understanding of the law to provide a comprehensive answer. However some did support the Review’s intention to compare the two systems.

82 Most of the respondents were not aware of any expected standards or processes for expert witnesses. There was however a general consensus that there should be a high standard applied to expert witnesses, especially those who are acting in the criminal courts. One respondent suggested that the zero prosecutions for CH was due to the fact that Scotland have a no-blame culture and their healthcare system is less litigious.

83 This section focuses on the professional regulatory process

84 What is your experience of the GMC's fitness to practise processes in cases where a doctor has been convicted of a serious criminal offence?

85 The GMC has a statutory duty to: promote and maintain public confidence in the medical profession, and promote and maintain proper professional standards and conduct for doctors. What factors do you think the GMC should balance when trying to fulfil both these duties where there have been mistakes that are ‘truly, exceptionally bad’ or behaviour/rule violations resulting in serious harm or death?

86 What information would you like to see from the GMC and others about the role of reflection in medical practice and how doctors’ reflections are used?

87 What emotional, pastoral and other support is available for doctors who have an allegation or charge of gross negligence manslaughter or culpable homicide and are being investigated by the GMC?

88 How can the learning from a fatal incident best be shared? Should the regulator have a role in this?

Finally...
Do you have any other points that you wish the review to take into account that are not covered in the questions before?
Annex B: Analysis of feedback and views sought from Responsible Officers for the independent review of gross negligence manslaughter and culpable homicide

We gathered experiences and views from a total 69 Responsible officers (ROs) across the UK in the NHS and independent sector via records of discussion with the General Medical Council’s employer liaison advisors (ELAs), who meet with ROs regularly. ROs were asked three questions in meetings with ELAs between 04 June and 10 August 2018 which were based on some of the main themes in the call for written evidence submissions. The questions focused on the support available to doctors, the role of local investigations and the GMC’s role in maintaining public confidence and professional standards.

Responses to individual questions

Question 1. Do you think doctors at all levels have access to sufficient support following a serious incident where it results in the death of a patient? Or other incidents? Have you been involved in developing this support? Could the processes for providing this support be improved?

There was a general consensus that whilst support for doctors had improved in recent years, it was still variable, insufficient, ‘often late in the day support’ or ‘patchy’ across individual organisations, team cultures and across all four countries. Some RO’s noted that there were pockets of support for doctors, for example if a death was investigated by a coroner’s court, but noted that support was mostly and often only short-term.

A couple ROs noted that doctors in training and SAS doctors can go to their consultant for support. Others say that employed doctors or those in ‘substantive roles’ are well supported via HR, whereas independent consultant, senior doctor or non-training grade doctor support will be more variable. Some say that support and willingness to accept or seek support depends on the doctor’s age or level of seniority and there is also a perception that... ‘senior doctors don’t need the support and that they should be able to cope. Also, [there is] a reluctance to ask for the help and be seen to need that support.’ Also they note that... ‘support is not there for locums, as there is no supervisor and no clear line of sight from Clinical Director’... ‘particularly, agency locums who may not do further shifts at the Trust.’ We are told that agencies can provide information about processes and pastoral support to doctors, but often this is reliant upon receiving good information from the organisation where the incident took place. This is often not provided or only limited details are given. One RO disagrees, saying that ‘locum doctors working at the Trust have access to the same support as substantive doctors.’

Whilst there may be local support available, external support is more difficult to access or find. Some say it depends on access to a Medical Defence Organisation (MDO) and claim that ‘membership is still a grey area’. One RO says they have ‘seen nothing that would suggest that doctors are supported. The Trust’s immediate concern is about litigation and the financial and reputational interests of the Trust. The interests of the
doctors are not supported. If doctor’s were given more support this would encourage a culture of learning and therefore of openness around reporting of incidents. There should be a welfare officer for doctors involved in incidents involving deaths/ Care Call.’

Examples given of support that is available includes, support from/through:

- Referrals to occupational health or counselling.
- Line management. For trainees, their educational supervisor and clinical director play supportive roles. Consultants are supported directly by the clinical governance team.
- Governance Leads who are normally involved in SI processes and are often a source of support, signing posting and de-briefing after major incidents.
- The Deanery/Local Education Training Board (for doctors in training).
- The RO themselves (when a concern about a doctor arises and the DB is using a disciplinary or capability route).
- An Employee Assistance Programme which has a confidential helpline.
- Support groups for all staff.
- Schwartz rounds.
- A Divisional Director, Service Lead, Training Programme Director, or HR.
- Mentoring networks (although noting that all of these things require investment and have to compete with other priorities for that investment in a system under pressure).
- A Trust’s legal department which has a set process to help doctors prepare for and support them during an inquest and informal support is offered by the clinical leads.
- Scotland’s Performance Support Unit for doctors in training.
- The GP occupational health scheme – “NHS GP Health Service”, (although noting that implementation has been slow).
- Valued peers or clinical colleagues.
- BME and BAPIO network.
- BMA and MDOs.
- A decision tool developed by the National Patient Safety Agency (In June 2012 the Agency became part of the NHS Commissioning Board Special Health Authority) and processes include a ‘hot debrief’ and feedback meeting.

- Psychologists accessible through the Trust.

One RO says that: An overarching framework of support is to be drawn up which will include the development of ‘Balint groups, 24 hour access and tailored support for those clinicians who are called to give evidence at Coroner’s court’.

Most noted that generally across the board the health service is not as good at managing support for doctors as it should be. There can be delays in providing support depending on where the doctor works e.g. if an incident happens in the community it can take longer for the relevant information to be shared with the right people. Further, many commented that even where there is support available, it is not always clear how it can be accessed or the uptake of it is not high, with some ROs saying that they will sign-post to support that is on offer locally. There is an expectation that doctors (and all staff) will ask for support rather than being proactively identified by the organisation as having been involved in the care of a patient that has died as a result of an SI and offered support. We were told that there should be more recognition that this [i.e. serious or fatal clinical incidents] can be a devastating event for doctors, particularly where there is also Police involvement.

Some say... ‘there needs to be a greater focus on the very early stages of any investigation process to ensure that the distinction between negligence and truly bad doctors is properly understood – in other words, to avoid doctors being subjected to unnecessary criminal proceedings.’ Some also highlighted that police investigation/coroner’s cases are particularly stressful.

Some also claim that ...’junior doctors are likely to be the most vulnerable to making mistakes – many are taking up full time work for the first time, they have significant workloads, they may be tired and will be required to multi-task.’ They also comment that... ‘trainees never see end of a process. Don’t get the long term support that permanent staff get.’ Another RO noted that... ‘when trainees are involved in incidents it can be the case that they are removed more quickly than other doctors from on-call rotas – this can impact on their confidence and lead them to becoming isolated.’ Others noted that there is a lack of support for junior doctors who are required to attend a Coroners Court. Citing the case of Dr Bawa-Garba, which they say has highlighted where additional support is required for doctors in training. It is recognised that earlier intervention could have led to additional support led by the Medical Defence Organisations. This RO says that their organisation is notified of SUIs via exception reporting, 2-3 weeks after the incident. In some cases, notification is received 12 months after the event. Earlier notification would improve ability to provide support at an early stage. General concerns regarding the level and range of reporting from Trusts following an incidents limits the support [org name] are able to offer.
However, others argued that the best example of support available for doctors on the whole is that which is currently provided for junior doctors. Saying that... ‘collectively, Deans are working to improve the support available to junior doctors identified in Never Events, SUIs, Coroners Court etc via a comprehensive support package which includes details on the process, sequence of events, high level principles, responding to the concerns.’ And that... ‘trainees have the Professional Support Unit (PSU) which is very robust although some trainees still do not know about it.’

Some ROs identified variance in the level of support and access to it depending on specialty or area the doctor is working in. For example, that... ‘provision of support is harder to manage in surgical and acute specialties.’ Whilst others commenting on their mental health trust say that:

In the case of suicides, the care-coordinator and nursing team involved are usually well supported but the patient’s doctor (who is often the responsible clinician) can be forgotten about unless they proactively seek help.

The serious incident reporting system doesn’t always identify the doctors involved in the patient’s care leading up to the incident. For example, the crisis team may make a decision to admit a patient who later goes on leave and commits suicide. The inpatient psychiatrist would be involved in the SI but not the crisis team. Whereas, a coroner would likely want a statement from the crisis team doctor. If the coroner isn’t involved the SI process doesn’t identify all those who may be able to take learning from it / may need support.

A number of ROs highlighted that being a General Practitioner (GP) is an isolating role and relies on the doctor seeking their own support. Partnerships are business relationships and don’t necessarily offer support when an incident occurs. Local Medical Committee support is dependent on the regime they wish to follow. Some ROs say that... ‘GPs are not always well supported... and there is a lot of pressure to just carry on and be ok. They [the ROs] see doctors who over compensate when things go wrong and may cause themselves unnecessary additional pressure. When investigations are done, not everyone is involved in the process. Frequently an investigation undertaken in secondary care comments on and may blame the GP but primary care are not involved in the investigation process or asked for comments. Primary care are generally bad at doing the investigations, in part due to nervousness about litigation and due to lack of skills and training. Never do a proper RCA [root cause analysis]. GPs can be naïve about risk management and processes e.g. naïve about contributing to coroner’s court proceedings. Are GP registrars taught about risk management / coroner process etc? Relatively rare in General Practice, non-palliative patients, most die within hospital setting. Erosion of continuity between doctor and patient – leads to stronger view that something could have been done / complaints. Fragmentation of care makes GPs more vulnerable. LEDA reviews – GPs singled out in complex multi-agency patients. MDT structure would help. Community care becoming higher risk due to patient complexity.’

One RO disagrees, saying: ‘GPs have support pathways in place.’
One says that their Trust is looking at suicides specifically and how to better support suicidal doctors. This same Trust says they use PDP groups, peer support groups and clear debriefs following serious incidents.

Some ROs say that they believe that their organisation is very supportive of doctors when things go wrong. They are conscious that teams tend to be devastated when serious incidents (SIs) occur. They try to reduce the impact on doctors by ensuring that doctors are not named in SI reports. When a death results in an inquest they try to support any doctors involved. In exceptional cases, where there is a suggestion that a doctor has lied, then they will adopt a tougher approach. In the case of SIs, the focus is on learning and prevention, and individual doctors are not named. Exceptionally at the end of an investigation process other actions may be required such as disciplinary processes. One RO says that the investigation reports in their Trust include a section for the Board to see what support was offered to the member of staff. Another says that what they have done is regular meetings/conversations with doctors using governance teams to work on risk, training and support.

An RO of a private healthcare organisation claims that:

‘The major changes that have taken place at [org name] in recent years mean that all doctors involved with Serious Incidents Requiring Investigation (SIRI) get informed of the investigation at an early stage and kept appraised of the progress of the investigation and the outcome. Other than this, we don’t offer specific support to doctors but we do make clear where they should be taking external advice, e.g. from their defence organisation. All SIRIs are investigated locally but reviewed on a weekly basis by the national Incident Review Working Group (IRWG). I sit on the IR WG and will advise on when individual doctors require support.’

There was some consensus that it is important to build a supportive approach into an organisation’s culture (although noting that it is not necessarily always well described in policies) – explaining that it has to be modelled by leaders within the organisation.

ROs provided the following suggestions for improvement:

- Support should be available from outside of the organisation in which the incident occurred - particularly for small organisations when many people will have been involved / will have an opinion

- Regional mechanisms / buddying arrangements with other organisations could be explored

- More consistent teaching around legal process and coroner activity. Not enough guidance and support for Doctors about how to handle these events.
• Should build into serious incident policy where patient has a consultant connected with them, making contact with the doctor as well as the rest of the team as a matter of routine.

• There may be a gap in support for doctors who are involved in the inquest process. This could be improved by employing a medical examiner within the Trust.

• When dealing with the regulator more local support could be offered.

• Set deadlines on the time taken to investigate could improve the experience from the doctor’s point of view.

• GMC BMA service could be better publicised.

• By the GMC telling RO immediately a doctor is being investigated, that allows me to put support in place asap for when the issue is disclosed to the doctor, after disclosure can be too late in terms of effect on health etc.

• Signposting and understanding of ‘menu’ [of support] could be improved.

• Would be helpful to have a template or guidance to set out what would be the best. Including support available also when GMC are involved, trust well supported. GMC support not face to face. Should be clear what GMC and employer can do balance clarity around support available. Is NCAS principle of keeping people in work being followed? Clarity of grounds of suspension etc.

Question 2. Have you been involved in work to improve the current arrangements for SI reporting and investigation? Do you have suggestions for further improvement so lessons are learned? Is there anything GMC could do to assist in this? For example, are there benefits in further embedding consideration of human factors in local investigations?

Almost all RO’s discussed how their organisation uses Serious Incident Frameworks and associated route cause analysis (RCA) techniques, with some describing how they were either in the process of reform of serious incident (SI) reporting and local investigations, or how they had already carried out reforms to their processes. Some highlight that they also have an independent external review carried out as well as an internal SI investigation. Many said that there will always be room for improvement of SI reporting and investigation processes.

There was general support for the use of human factors assessments (which some argue RCA misses). However, there was slight variance in regards to how the use of human factors should be embedded and some recognition of potential limitations to such an approach. A couple ROs report that consideration of human factors is already part of the process (i.e. SIs already look at the wider context e.g. whether or not there was a full complement of staff on duty, the skill mix and workload), some say they
provide human factors training for staff, and another reports that ‘human factors training is in place for certain areas, but could be extended. NatSSIPs and LocSSIPs are important in this. Key is identifying early everyone involved in an SI, in order to detect patterns of concern.’ It was noted by some others that human factors assessment is a relatively new concept in healthcare (and behind other industries); with almost all respondents suggesting that further work is required to properly embed this everyday practice and one RO suggesting that a national framework re human factors is needed.

A couple of ROs claim that whilst thematic analysis is preferential, it is time consuming and RCA is much quicker. However, others highlight that RCA very rarely raises anything new that medical leaders are not aware of and that the RCA… ‘process feels formulaic at times and doesn’t capture the need to reflect on things in a blame free environment.’ One RO says their organisation is working with the Academic Health Science Network – a patient safety collaborative, on new arrangements which will focus on triangulating learning from SIs, mortality data and complaints; pulling themes together and applying human factors. Stating that… ‘outcomes will be aligned to quality improvement projects.’

Another RO recognises that whilst… ‘human factors are no doubt important, the key deficiency is in recognising, characterising and rectifying system failures. Further focus on human factors is likely to reinforce the current tendency to look to failures at individual level - and delay the recognition that focussing on systems which are failure-prone are far more likely to prove fruitful in reducing preventable harms.’

One RO highlights that it’s important to have professional investigators rather than expect busy clinicians to undertake SI investigations on an ‘ad hoc’ basis. Investigators should be committed, interested and neutral so the process is objective and consistent. Processes could be improved by making sure there is sufficient resource, skills and capacity. Quality issues can arise when clinicians who are already under significant work load pressures and may not have the relevant skills and experience are tasked with conducting a SI investigation. One RO says that as part of the reforms to their processes they plan to… ‘make sure that the people undertaking them are trained and have the skills, time and resources to do them.’ However another RO queries… ‘all investigators properly trained, what exactly does that mean! Trained by whom, what national standard are we referencing. Lots of clarification and improvement required!’

Further areas that the ROs plan to reform includes support for families which will be improved by appointing family liaison personnel - a service modelled on Birmingham Children’s Hospital’s bereavement service. Others plan to… ‘link reforms to NHSI’s Learning from deaths guidance, implementing standardised decision making, utilising different levels of investigation and embedding human factors within the process.’

Areas already improved included:

The use of specific schemes, boards or committees to ensure learning post incident. For example, Health Education England - North West: Postgraduate Medicine and Dentistry, offers a Lessons Learned Scheme – where foundation doctors come together to
confidentially discuss concerns to improve understanding. One RO carries out seminars where SIs are themed and presented in an anonymised manner so that lessons can be identified and learnt.

Another RO highlights that... ‘the quality, consistency and timeliness of the Trust’s SI investigations has greatly improved due to investment of resources in a dedicated team of investigators around six years ago. The Trust has 4 full-time posts with staff from different backgrounds, including police. The Trust also has 6 medical SI investigators, who have a dedicated session a week to provide clinical input to investigations. The Trust has an MDT risk panel which reviews every incident each week as it happens, oversight of every SI at every stage rather than just waiting to see the report at the end. Again this has paid dividends in terms of consistency.’

One says that in their organisation... ‘a weekly patient safety summit takes place which reviews Datix entries. The 3 top lessons learned are shared with staff via the staff bulletin. Lessons learnt are also collated following patient complaints and SIs and used as an early warning system.’ They also report that... ‘staff are undergoing Human factors training to encourage fairness into the processes.’

Another new initiative we were told about is, the Corroboration Forum, which has been set up which considers the results of audits and discusses SI’s and near misses before identifying themes/problems. The priorities are then disseminated in a more user-friendly way.

We were told that in Wales, all organisations are required to report all Never Events/Serious Untoward Incidents/ "no surprises“ incidents to Welsh Government. Local investigations follow all – Wales UPSW requirements. However, we were told that it is... ‘unclear how/ if lessons are drawn from composite reporting or how/if Welsh Government disseminates this out.’ Another RO... ‘hopes that the inauguration of Health Education and Improvement Wales may improve all-Wales learning.’

Some ROs highlighted the following areas for improvement:

- Timing is an issue. Speed is required but the process also has to be thorough. This is challenging for the doctor waiting for the issue to be resolved. Internal processes do not allow doctors time to deal with the investigation within work hours, making the point that often the evidence is several ring binders worth of paper.

- There is inconsistent bias in local investigations.

- The standard against which doctors are measured is not always clear e.g. if a trainee is involved then there should be a clear link to the curriculum to show that they ought to have had the relevant skills/knowledge – this might help to identify gaps/themes in training.
• Would welcome consistent or standardised approach to SI investigating and reporting. Definition of SI is still open to debate. E.g. cancer pathway, delay, have you caused harm, don’t know, may have died anyway – it’s not an effective way of getting to bottom of things and learning. Clarification as to what constitutes an SUI or Never Event could improve reporting by Medical Directors and Medical Education Managers.

• Need more work on what duty of candour means in SI investigations.

• Need to get better with patient and family involvement. Also junior docs and language of reports.

• More needs to be done to engender a culture which helps people to be open and is more accepting of mistakes.

• ‘Deciding officers’ are not always aware of the implications of decisions on the doctor’s professional responsibilities to the regulator – this is being reviewed, so that they are able to seek advice as part of the investigation process.

• Doctors need to know what happens with the information that goes into the reporting tool and how this links to reflection.

• Need less structured reviews and to have debriefing which is a better form of learning than a formal investigation. Particularly in areas like suicide where in retrospect things could have been done differently but nothing caused the suicide. Useful to discuss the impact of the event amongst practitioners and ask what they would like to have seen happen.

The most commonly reported, ‘biggest challenge’ remains disseminating the learning. ROs say that for example... ‘all efforts are made but junior doctors can be transient. The junior doctors forum is well attended however much of the process assumes that clinicians will read the output of the SI investigation.’ Another claims that they are...‘good at identifying root causes and developing action plans and the team involved will institute the action plan but whether that amounts to proper learning is not clear. It can be a somewhat procedural response. Some improvements might be short-term and not achieve behavioural and cultural change and embedded sustained learning. In the health service the same serious incidents recur with the same root causes. Contrast with the airline industry where the focus is absolutely on sharing and embedding learning so it cannot happen again.’ They argue that we need to do more than simply disseminate Never Event reports. There is a need to take a more sophisticated approach. All the Never Events that have occurred at their Trust recently have resulted in processes where there is a WHO checklist. The issue is what led to the checklist not being followed.

Is there anything GMC could do to assist in this?
Responses to this part of the question included suggestions that:

- The GMC might be able to pick up lessons learned and professional themes running through SI investigations and disseminate these through ELA meetings or via the RO network which might be helpful - analogous to the flash report system operating in the airline industry.

- If the GMC could assist in providing resources, that would be helpful as this is a resource-intensive activity.

- The GMC could do more to reassure the profession that providing treatment to patient that is subsequently subject to an SI investigation does not equate to a GMC investigation – ie systems investigations are not for the GMC.

- There is no clear role for the regulator here - it is a local responsibility to look after staff. However, the GMC could share local learning from elsewhere.

- The role of the GMC’s ELAs was appropriate in this regard and how ROs find this relationship/source of assistance helpful.

**Question 3. The GMC has a statutory duty to promote and maintain public confidence in the medical profession and to promote and maintain proper professional standards and conduct for doctors. How do you think the GMC should act to maintain public confidence and professional standards where there has been a conviction for GNM (Culpable Homicide)**

This question, understandably, focussed on the Dr Bawa-Garba case with many responses focussing on the issues raised in this case (N.B. These discussions with ROs were had before the outcome of the judgement of the Court of Appeal). There was a mixed response from RO’s on this question. Some felt that the GMC were in an ‘impossible position’, that a consistent approach to these cases was important, and that ‘the GMC should retain its right of appeal’ (following the Williams review recommendation to remove it). A number of ROs commented that they thought that the GMC ‘were bound to act,’ and/or, ‘would have no choice other than to seek erasure following a conviction for GNM’ and that ‘doctors must be trust worthy and this does not align with being convicted of a serious criminal offence’.

One RO says more generally in response to the question... ‘it is a difficult balance between maintaining public confidence and being fair and not punitive to the doctor involved.’ Another says that it is... ‘important that the GMC is seen as a body that protects patients and therefore it is hugely important that it is public facing as well as supportive to doctors. Where there are serious cases of misconduct etc the GMC should use all of its powers to protect patients.’

However, there were some RO’s who felt that the GMC should have respected/trusted the judgment of MPTS in the case of Dr Bawa-Garba and that it was unnecessary to always presume erasure for a serious conviction. Many commented that the GMC should
not take a fixed or formulaic approach to dealing with cases (particularly conviction cases) and that it should take a more ‘pragmatic,’ ‘flexible’ or ‘holistic’ approach to take account of the individual facts and circumstances of each case (including the working environment, number of deficits leading to the patient’s death, and any aggravating or mitigating factors eg remediation.)

*Communication and transparency*

The GMC was also encouraged to:

- take a more courageous position
- work on its reputation and promote positive aspects of doctors work as well as its own
- think about the way it communicates on these matters. For example be clear that such a conviction is not compatible with being on register in the way the GMC does with other convictions
- demonstrate an open and learning culture
- talk about its processes in an open and transparent manner - need to be clear what they are interested in and not.

Furthermore ROs recognised or highlighted that:

- The GMC is in a difficult position balancing communications with the family and media, but should be better equipped to manage communication
- The GMC should still act as they did but need to be more prepared to deal with comms when they occur. A lot of this could have been avoided by appropriate prep and comms
- Quicker response from GMC, need to get accurate information out there to reassure doctors via the Chair of the GMC. General issue is pace of GMC in general matters undermines its credibility. Regular updates would be helpful.
- If the public understand the role of the MPTS better, they might respect the decision – not to punish. There is an opportunity to give a more nuanced message perhaps, especially for the public, in relation to the importance of ensuring reflective practice.
- The GMC [has a] closed door, [the] public and profession don’t know if GMC is looking at something and have dealt with it, not transparent. HCPC monthly update on who is being investigated – good practice.
- There is an overall perception that the GMC wants to please the public rather than protect the public (difference between ‘needs’ and ‘wants’).

- There is a feeling that the GMC didn’t like the outcome and appealed that was more about GMC justifying its existence rather than protecting patients.

- The GMC should investigate and maintain under the standard set by Good Medical Practice. A conviction should not necessarily result in sanction from the GMC unless the standards of Good Medical Practice have not been met. Doctors should be assessed by the same standards of Good Medical Practice, irrespective of any criminal conviction for any offence.

They also queried whether the decision to appeal truly was in the interests of maintaining public confidence in the profession, given the strong felt opinion that Dr Bawa-Garba could have remediated. Others questioned whether the GMC reflected and learned from its decision to appeal and asked whether it was a single decision maker who decided to appeal MPTS’ decision, highlighting that collective decisions by more than a small group of individuals would be best.

One RO highlighted that the current GMC approach to look locally and speed up referrals is good. Speed is important as the process has impact personally, reputationally and for practice (especially when private).

Comments in regards to the law of GNM and the criminal part of the process leading up to a conviction

Many ROs demonstrated that they felt that the real issue lay with the criminal conviction in the first place. They noted that the route to conviction of a doctor for GNM needs to be considered, so that only the ‘right’ cases reach that stage, commenting also that ‘the vagaries are in the judicial system.’ And that it is the law of GNM in the medical context that needs to be reviewed - ‘GNM needs to be better defined. And the reasons for conviction need to be clearer so that public and profession understand the severity of actions that lead to such a conviction’... ‘It is fundamentally a problem in court of law - who gave evidence? Must have been a medic, an expert who was not properly challenged.’ Also highlighting that... ‘the concerns of doctors arising from the recent case of Dr Bawa-Garba arose primarily from the original Court decision. While the GMC had acted appropriately from a legal perspective its actions had increased the anxiety of doctors,’ and that... ‘No doctor sets out to deliberately harm patients. The public require confidence that the clinical governance systems which allow terrible mistakes to happen have been sorted out and assurance that the doctor is not incompetent.’ One RO thought that... ‘the NHS culture of denial and keeping things quiet also needs to be addressed.’

Another said in regards to juries... ‘It is difficult for lay juries to understand the complexities of an emergency healthcare environment... Juries holding doctors to a higher standard is not unreasonable but cannot be held to position of perfection’...
'There is a risk that the complexities of the systems in which doctors work are overlooked'. This RO queried: Can the GMC and CPS/Prosecutors do more work together to ensure concerns are dealt with by the appropriate authority? Additionally, an RO reported the issue of GMC and police potentially coming to different conclusions. Timing and sequence of local, GMC and police investigations is a real challenge, in particular whether these run in parallel or local and GMC should wait for police to conclude, which can take a long time. One RO noted that... ‘the police seem to be looking at an increasing number of cases with a view to considering a GNM charge. This is having a significant impact on doctors.’ Another RO highlighted the disparity in the law of GNM and CH, saying that they... ‘acknowledge also the postcode lottery and the differences between Scotland and England and Wales’... ‘If doctors make mistakes there can be serious consequences for them. This can create a barrier to openness and candour. Anything that could mitigate the threat of inappropriate prosecution and the risk of erasure would be welcomed. For example, England could adopt something more like the Scottish approach.’ This suggestion was supported by a number of ROs.

One RO raised general concerns regarding the lack of availability of clinical supervisors, the need to improve reporting systems to enable concerns to be reported and engaging Guardians in discussions at an earlier stage. Royal Colleges need to rethink the process for reflective practice and the role it can play in development and learning. Suggestions include a menu of reflective practice, templates and focused learning.

Another raised the concern over apparent disparity in threshold between GMC and NMC – causes resentment in nursing staff.
# Annex C Respondent category analysis

## Table 1: Total number of submissions categorised by respondent type

<table>
<thead>
<tr>
<th>Category</th>
<th>Total responses</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient representative organisation</td>
<td>4</td>
<td>0.55%</td>
</tr>
<tr>
<td>Patient or family member of patient</td>
<td>25</td>
<td>3.43%</td>
</tr>
<tr>
<td>Medical Professional</td>
<td>607</td>
<td>83.26%</td>
</tr>
<tr>
<td>Medical Student</td>
<td>2</td>
<td>0.27%</td>
</tr>
<tr>
<td>Legal Professional</td>
<td>5</td>
<td>0.68%</td>
</tr>
<tr>
<td>Academic</td>
<td>10</td>
<td>1.4%</td>
</tr>
<tr>
<td>Police</td>
<td>1</td>
<td>0.14%</td>
</tr>
<tr>
<td>Prosecuting Authority</td>
<td>0</td>
<td>N/A</td>
</tr>
<tr>
<td>Employee of the criminal justice system</td>
<td>0</td>
<td>N/A</td>
</tr>
<tr>
<td>Coroner, Procurator Fiscal or part of the coronial service</td>
<td>1</td>
<td>0.14%</td>
</tr>
<tr>
<td>Professional Representative/ organisation or Trade body</td>
<td>37</td>
<td>5.07%</td>
</tr>
<tr>
<td>Defence organisation</td>
<td>3</td>
<td>0.41%</td>
</tr>
<tr>
<td>Professional regulator</td>
<td>6</td>
<td>0.82%</td>
</tr>
<tr>
<td>Systems Regulator</td>
<td>2</td>
<td>0.27%</td>
</tr>
<tr>
<td>Voluntary organisation/charity</td>
<td>4</td>
<td>0.55%</td>
</tr>
<tr>
<td>Government Department</td>
<td>1</td>
<td>0.14%</td>
</tr>
<tr>
<td>Other healthcare Professional</td>
<td>9</td>
<td>1.23%</td>
</tr>
<tr>
<td>Other</td>
<td>12</td>
<td>1.65%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>729</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

## Table 2: Submissions received via online survey

Please see table 2 and table 3 for the breakdown between submissions received online (table 2) and those received via the inbox (table 3).
<table>
<thead>
<tr>
<th>Type Of Respondent</th>
<th>Category</th>
<th>Total responses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Legal Professional</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Academic</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Police</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Prosecuting Authority</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Employee of the criminal justice system</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Coroner, Procurator Fiscal or part of the coronial service</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Professional Representative/ organisation or Trade body</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Defence organisation</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Professional regulator</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Systems Regulator</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Voluntary organisation/charity</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Government Department</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Other healthcare Professional</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Medical student</td>
<td>2</td>
</tr>
<tr>
<td><strong>Patients</strong></td>
<td>Patient representative organisation</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Patient or family member of patient</td>
<td>21</td>
</tr>
<tr>
<td><strong>Total patients, family members and/or patient representatives</strong></td>
<td><strong>23</strong></td>
<td></td>
</tr>
</tbody>
</table>

To note: there were a number of respondents that did not select ‘medical professional’ in the categories above but selected one or more of the sub categories below, eg some selected ‘academic’ above as well as ‘consultant’ below. There was also a number of respondents that selected ‘medical professional’ who selected two or more sub-categories below.
<table>
<thead>
<tr>
<th>Type Of Respondents</th>
<th>Category</th>
<th>Total responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal Professional</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Academic</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Police</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Prosecuting Authority</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

**Table 3: Submissions received via the inbox**

Please see Annex A for a list of individuals/organisations so you can quality assure against the Livelink folder found [here](#).

This has been drawn from the data collated on the smart survey which you can quality assure by going to survey results and then clicking on key analysis (you should be able to see graphs for respondent type).
<table>
<thead>
<tr>
<th>Employee of the criminal justice system</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coroner, Procurator Fiscal or part of the coronial service</td>
<td>1</td>
</tr>
<tr>
<td>Professional Representative/ organisation or Trade body</td>
<td>22</td>
</tr>
<tr>
<td>Defence organisation</td>
<td>2</td>
</tr>
<tr>
<td>Professional regulator</td>
<td>4</td>
</tr>
<tr>
<td>Systems Regulator</td>
<td>1</td>
</tr>
<tr>
<td>Voluntary organisation/charity</td>
<td>0</td>
</tr>
<tr>
<td>Government Department</td>
<td>0</td>
</tr>
<tr>
<td>Other healthcare Professional</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
</tr>
<tr>
<td>Medical Student</td>
<td>0</td>
</tr>
<tr>
<td><strong>Patients</strong></td>
<td></td>
</tr>
<tr>
<td>Patient representative organisation</td>
<td>1</td>
</tr>
<tr>
<td>Patient or family member of patient</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total Patients and/or representatives</strong></td>
<td><strong>5</strong></td>
</tr>
<tr>
<td><strong>Medical Professional</strong></td>
<td></td>
</tr>
<tr>
<td>Doctor in training</td>
<td>0</td>
</tr>
<tr>
<td>General Practitioner</td>
<td>0</td>
</tr>
<tr>
<td>Consultant</td>
<td>4</td>
</tr>
<tr>
<td>SAS grade</td>
<td>0</td>
</tr>
<tr>
<td>Locum</td>
<td>0</td>
</tr>
<tr>
<td>Responsible Officer</td>
<td>0</td>
</tr>
<tr>
<td>Medical Director</td>
<td>1</td>
</tr>
<tr>
<td>Clinical Director</td>
<td>0</td>
</tr>
<tr>
<td>Educational Supervisor</td>
<td>0</td>
</tr>
<tr>
<td>Retired Doctor</td>
<td>1</td>
</tr>
</tbody>
</table>
### Total Medical Professionals

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>44</strong></td>
</tr>
</tbody>
</table>

### Medical professionals: breakdown of type most associated with

<table>
<thead>
<tr>
<th>Medical professional</th>
<th>Response Percent</th>
<th>Response Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Doctor in training</td>
<td>17.07%</td>
<td>106</td>
</tr>
<tr>
<td>2 General practitioner</td>
<td>25.44%</td>
<td>158</td>
</tr>
<tr>
<td>3 Consultant</td>
<td>45.57%</td>
<td>283</td>
</tr>
<tr>
<td>4 SAS grade</td>
<td>4.19%</td>
<td>26</td>
</tr>
<tr>
<td>5 Locum</td>
<td>2.58%</td>
<td>16</td>
</tr>
<tr>
<td>6 Responsible officer</td>
<td>1.13%</td>
<td>7</td>
</tr>
<tr>
<td>7 Medical director</td>
<td>2.42%</td>
<td>15</td>
</tr>
<tr>
<td>8 Clinical director</td>
<td>1.93%</td>
<td>12</td>
</tr>
<tr>
<td>9 Educational supervisor</td>
<td>6.44%</td>
<td>40</td>
</tr>
<tr>
<td>10 Retired doctor</td>
<td>8.37%</td>
<td>52</td>
</tr>
</tbody>
</table>

### Analysis

- **Mean:** 4.15
- **Std. Deviation:** 2.9
- **Satisfaction Rate:** 33.33%
- **Answered:** 621
- **Skipped:** 63