9th August 2018

The Doctors’ Association UK written response to the Dame Clare Marx/Leslie Hamilton review

Dear Mr Hamilton,

In the wake of the case of Dr Hadiza Bawa-Garba doctors are angry and fearful. Angry, that someone like them, who was just trying to do their best for patients in a system at breaking point, has faced criminal prosecution and erasure from the medical register for what many feel were essentially honest mistakes. Fearful, that a simple error will see them subject to criminal proceedings, in which their written reflections will be used against them and taken to court by their regulator to have their career ruined.

We, The Doctors’ Association UK (DAUK), were formed in response to the fear and anger that has united our profession. The Doctors’ Association UK is an independent campaigning and lobbying organisation, which aims to speak out on issues that matter to UK doctors and the NHS as a whole. The steering committee has achieved significant successes in a short space of time, such as coordinating 4500 doctors and members of the public as joint signatories to a letter to Charles Massey, GMC Chief Executive, successfully campaigning on Tier 2 visas for doctors and speaking out in the media both in print and on TV and radio. We are currently campaigning for radical reform of the way medical error is approached in the UK, in a campaign called “Learn Not Blame”.

The GMC commissioned review which you are conducting is a key step in this process. Following from the rapid review conducted by Sir Norman Williams we hope that your review will build on and go further towards the much-needed progress on achieving a just culture within the NHS.

The actions taken following your review will be vital to going some way to restoring the profession’s confidence in their regulator. We see the review as an opportunity where the GMC can reform and start to rebuild the trust that was lost over the last few years and as a result of the Bawa-Garba case.

Our recommendations to the review, in summary are:

1. A higher bar for the CPS to consider pursuing a prosecution for GNM.

2. The law on gross negligence manslaughter (GNM) be urgently reformed, with a legal test of GNM related to healthcare to include actions of being “wilful or reckless”, and system failures considered as mitigation.

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1 https://inews.co.uk/news/health/dr-hadiza-bawa-garba-anger-striking-off/
3. Appropriate training in Human Factors for all investigators. This would involve local investigators as well as prosecutors and medical expert witnesses.

4. Formal appraisal of medical expert witnesses under the governance of the Medical Royal Colleges

5. Written reflections undertaken by doctors for the purposes of education or training be subject to legal privilege

6. An amendment to Section 35A (1A) of the Medical Act 1983 that currently allows the General Medical Council (GMC) to compel doctors and organisations to disclose written reflections for fitness to practice hearings

7. The repeal of Section 40A of the Medical Act that allows the GMC to appeal MPTS verdicts, in keeping with the recommendations of the Williams review.

8. Assurance from the Department of Health and Social Care that Parliament will not grant the GMC the power of automatic erasure for the offence of Gross Negligence Manslaughter.

9. The GMC conducts a comprehensive review into unacceptable high rates of BME doctors referred and undergoing fitness to practice investigations.

10. The GMC addresses how it has become weaponised where threats of referral are made to deter and silence patient safety concerns.

11. The GMC launches a formal review of its processes and how these are linked with the unacceptable number of doctor suicides whilst under investigation.

We are happy to present our evidence in person and look forward to engaging with you on this review. We will of course be attending your upcoming working groups.

Yours sincerely,

The Doctors' Association UK
5. The name of your organisation or employer and location

The Doctors' Association UK

6. Your email address if you are happy for us to contact you about your submission

contact@dauk.org

7. Please select the group below that you feel applies most to you or the organisation you are responding on behalf of:

Medical Profession

8. If you are a medical professional, please select the options below that apply to you:

We are a grassroots campaigning and lobbying organisation aiming to speak out on issues that matter to UK doctors and the NHS as a whole.

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

We believe that a death can be considered to be a criminal act where there is a clear intent to cause harm to a patient. A mistake where wilful harm, deliberate recklessness or continued deviation from established protocols may be considered to be a criminal act. In recent years the terms “truly exceptionally bad” have been used to signify that a criminal act has been caused towards a patient. We believe that this is vague and misleading statement that is open to a wide array of misinterpretation and misrepresentation in court. The application of “truly exceptionally bad” when describing the actions of a doctor is reasonable if considering their knowledge or competence alone. It loses context when applied to a situation of worsened performance under pressure.

It is imperative however that the judicial system recognises that mistakes and human error are often the result of multiple factors, often spanning a significant period of time and outside the control of the medical practitioner making the error. Furthermore, system failures resulting in harm and the death of patients may in some cases be the consequence of a series of similar unintended mistakes. It must be recognised that individuals working in a system which is failing should not be held responsible for the death of a patient, especially where the removal of systemic failures may have contributed to a better outcome. A supportive culture of learning and not apportioning blame or punishing individuals is required so that clinicians have faith in reporting their mistakes or system failings.

10. What factors turn that criminal act into manslaughter or culpable homicide?

The Doctors' Association UK believes that there are a multitude of factors that turn a criminal act into manslaughter or culpable homicide. These, of course need to be considered on a case by case basis. The background, environment and circumstances that the medical practitioner found themselves in should be considered when making the determination that a criminal act is severe enough to warrant the charge of manslaughter or culpable homicide. Furthermore, as above, intent to cause harm or suffering should be considered when considering whether manslaughter or culpable homicide has been committed. Currently, guidance in the form of an act which was
“truly, exceptionally bad” has been used since the Misra case\(^2\). The utility of this set of words, we feel is limited as outlined above. It leaves room for ambiguity especially when the full details of the case are not disclosed to the jury.

In Scotland, the use of involuntary culpable homicide as an offence is akin to gross negligence manslaughter in England and Wales. Central in these cases is the need as a result of case law to proving the mens rea or guilty mind. It is therefore deemed vital in cases in Scotland of Involuntary culpable homicide for the mens rea to be determined. We feel that going forwards, a Scottish-style consideration of intent should be adopted by the other nations.

11. 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?

It is vital that families are given the explanations they need following the death of a relative as a result of a serious clinical incident. Often family members do not feel that they are considered when an investigation takes place. Families want to hear about the circumstances of the death, whether mistakes were made and what solutions have been put in place to prevent similar mistakes in the future. Often family members feel that investigators, managers and clinicians seem to create a culture of secrecy and cover-up. This can be seen in multiple cases including the Gosport War Memorial Hospital independent panel report. All too often investigations seek to apportion blame to an individual. This results in opportunities to learn as an organisation being missed in favour of a process against individuals. In these situations, the focus often shifts towards legal cases and away from learning and making changes that would prevent future harm, something that is central to what families desire. This is in keeping with what was reported by the CQC in 2016 where families reported that learning was often not clear\(^3\).

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?

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.”\(^3\) 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.”\(^3\)

We feel that family involvement is vital to an investigation from the outset. It is important for families to feel that there is an openness and that the duty of candour has been fulfilled. The Doctors’ Association UK feel that this must however also be balanced. In rare circumstances families, due to the adversarial investigation process, may seek to blame individuals where other circumstances or systemic failings have contributed significantly towards a death. It is important for this process to command the faith of both clinicians and families so that both can be convinced that a robust, open and fair investigation has been conducted.

\(^2\) R v Misra and Srivastava [2005]

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?

National guidance recommends that trusts should appoint specially trained staff as family liaison officers. Many trusts do not have specially trained family liaison officers who are equipped to deal with these matters. We feel that the space for families to have these conversations, to understand the series of events following fatal clinical incidents is not as readily available in many cases. Mediation suggests conflict or disagreement, often this is not the case and families just require the time and access to specially trained staff to understand the events leading up to the clinical incident. Mediation may be useful at times where there is a disagreement between a family and the healthcare provider, it must be mutually acceptable to everyone involved and may prevent further escalation and closure for the family.

14. How are families supported during the investigation process following a fatal incident?

The 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 training, skills and expertise of staff involved in supporting the bereaved is seen to be inadequate in many institutions according to the CQC. We welcome the new National Guidance on Learning from Deaths. To complement this, we would call for new guidance setting out minimum training requirements and the requirements of refresher training for all staff responsible for dealing with the bereaved.

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

The Doctors’ Association UK (DAUK) feels that a culture of learning from clinical incidents rather than apportioning blame is direction that the NHS needs to move in. With that in mind we will be driving forward our #Learnnotblame campaign over the coming months.

DAUK feels that investigations need to be truly open, transparent and involve both patients and their families as well as all staff members involved in the incident. Trusts should ensure that the outcomes of the investigation will be implemented promptly to genuinely improve performance and patient care rather than protecting personal or corporate reputation. The recommendations of such investigations should be made public as should evaluations to ensure that the recommendations have been acted upon.

We seek to develop a #Learnnotblame culture within trusts where individual healthcare workers and organisations actively look to learn from both good and poor practice. We hope

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to campaign for a step change in the NHS so that an honest error is used to drive learning and change for a safer, better NHS, rather than being a focus for individual blame. Learning and sharing lessons from clinical incidents is key to improving both individual and organisational performance and the quality of care offered to our patients. An open culture without fear of victimisation, blame or bullying of clinicians will ensure that healthcare workers feel more able to speak out about their experiences. An organisational culture where employees are encouraged to speak up and input welcomed and acted upon engenders the development of a just culture.

The DAUK welcomes the development of an independent body, separate from the NHS, to take forward the work of the HSIB. However, to truly achieve confidence from patients and healthcare professionals the HSSIB should also be independent from the government. Despite the pre-appoint scrutiny by the Commons Health and Social Care Committee, the powers that the Bill grants to the Secretary of State for Health to appoint the Chair of HSSIB and the Chief Investigator, we feel will limit its independence and wider public confidence in its investigation results.

To be effective in initiating a cultural change in safety investigations in the NHS there must be confidence in the “safe space” to allow staff to speak freely and to engender wider learning in a blame-free culture. The GMC’s handling of the Dr Hadiza Bawa-Garba case and the treatment of Dr Chris Day, an NHS whistle blower by Health Education England have both served to lead to a tremendous loss of confidence in safety investigations among doctors.

We recommend that minimum standards should be set outlining the support that healthcare providers should provide bereaved families and carers building on the National Guidance on Learning from Deaths. Their experiences of the care received by their loved ones may help to improve future patient safety or patient experience.

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.

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?

We believe that the current arrangements for reporting and investigating serious clinical incidents are neither effective nor fair. The issues involve a lack of training and dedicated staff to conduct investigations and a lack of support for staff involved in serious incidents.

A dedicated team of staff, with up-to-date training on conducting investigations is required. We feel that an investigation team should always comprise of a clinician with adequate experience of the clinical setting. Where a conflict of interest is suspected, an independent external clinician may be appropriate. It is imperative that all parties involved in the investigation have confidence that the investigating team and organisation will treat them fairly.

With respect to staff involved in serious incidents there is a woeful lack of support locally. It has been reported that in some institutions the environment is adversarial and unfairly punitive towards staff involved in serious clinical incidents. Furthermore, a culture exists where whistle blowers are punished, victimised and their careers ruined. Examples such as Dr Chris Day, Mr Edwin Jesudason and Dr Raj Mattu serve as chilling examples of whistle
blowers that have been targeted and the learning for patient safety changes that may arise from their reports simply side-lined.

We are further concerned about what seems to be a weaponising of the General Medical Council. The GMC investigative process is lengthy and distressing to those subject to it. It has emerged that occasionally that trusts are using the threat of GMC referrals to not only silence whistle blowers but also the free press in the notable case of Professor Edwin Jesudason. This calls into question the motives of NHS trusts who in such circumstances feel that it is more important to silence whistle blowers than investigate concerns fairly and admit that organisational changes need to be made. This is clearly at odds with the creation of a just culture.

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.

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.

The Doctors’ Association UK feels that human factors training for local investigators should be made mandatory. Specific human factors training that relates to healthcare settings is key when investigating whether a multitude of factors, including system failures, have contributed to a clinical incident. We would recommend that regular human factors training updates be undertaken by all local investigators and that the Care Quality Commission look to examining trust compliance with this training as part of their review process.

18. 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?

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.

19. How is the competence and skill of those conducting the investigations assessed and assured?

There is currently no record of competence or skill of investigators that we are aware of. As outlined above, we think that 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.
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? If so, please email a copy to ClareMarxReview@gmc-uk.org

A nationally agreed protocol which can be locally adapted would aid in helping healthcare providers to ensure that they are doing all that is necessary to properly investigate serious clinical incidents.

21. What measures are taken to ensure the independence and objectivity of local investigations in hospital/trust/board or other healthcare settings?

It is difficult for us to see what measures are taken locally. We have commented on the importance of ensuring that there is no investigator conflict of interest. A process should be in place to review and deal with complaints about bias and a lack of independence in investigations.

22. What is the role of independent medical expert evidence in local investigations?

There are currently no requirements that we are aware of that mandate that independent medical expert evidence is required in local investigations. As we have stated above, the medical expert is often another member of the team. We feel that if concerns are raised about the impartiality of this person or a conflict of interest is identified then any party should be able to call for a mutually agreed external independent medical expert.

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?

Independent medical experts are rarely used currently in local investigations, the majority of which use existing employees as medical experts. We advocate the use of mutually agreed external independent experts where a conflict of interest with local investigators is suspected. We are not aware of specific criteria used when selecting independent experts or how they are instructed. Independent experts are much more likely to be instructed by the Police or Crown Prosecution Service than by an individual healthcare trust.

24. Are there quality assurance processes for expert evidence at this stage, if so, what are they?

There is currently no quality assurance processes that we are aware of for experts who give evidence. Ongoing appraisals as part of their clinical work and GMC revalidation are the only quality assurance processes that we know to exist. Our concern is that these appraisal processes may not be robust enough to appraise the provision of medical expert evidence. Furthermore, 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. We would therefore call for clarity on the appraisal process of medical expert witnesses from the GMC and Medical Royal Colleges.

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)

Response given above.
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 is no formal organisational support for doctors that DAUK are aware of. Doctors often find it difficult to ask for support at such times, fearing breaching patient confidentiality or jeopardising educational or career progression. As a result, doctors often find it difficult to speak to peers, educational supervisors or managers, the result is isolation of that doctor at a time where they need to be supported in the immediate aftermath of a patient death but also through the ensuing investigation.

Emotional and mental health support following the death of a patient is also extremely limited. Doctors often never present, or present late to their General Practitioner following a serious clinical incident. As a result, the impact on their emotional or mental health is often not realised till much later in the process. In addition to this, referrals to the General Medical Council and the launch of formal investigations and fitness to practice proceedings has been linked to a number of doctor suicides. The Practitioner Health Programme (PHP) is a London-based service to which doctors living in London can self-refer. Doctors residing outside of London need funding approval from their General Practitioner or NHS Commissioning board. This therefore limits accessibility to this valuable programme depending on where a doctor resides. Access and funding to this programme should be made available to all doctors across the country, acknowledging that the lacuna in funding adds to additional stress and anxiety at a time when an individual may already be vulnerable.

Educational support from Health Education England or its subsidiaries is often not forthcoming. Individual doctors often have to seek the support themselves. In many cases this involves referral to Professional Support Units from which assessments and further referrals can be made. It is imperative that Educational Supervisors remain objective and understand that they may be the person that doctors reach out to for support and guidance. 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.

Legal advice can be obtained privately by an individual or by members of a medical defence organisation. Professional support in terms of disputes with an employer can be sought from a trade union.

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?

Referrals to the coroner are usually made by clinicians if the death has been due to any unnatural event, process, intervention or act that may have contributed to the death more than minimally or negligibly. Furthermore, a 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. Local mechanisms exist by which coroners request referrals from Medical

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Practitioners either via a paper or electronic form. It is generally coroners who refer cases to the Police however there is widespread inconsistency as to which cases to report. Consistent guidance needs to be developed to assist coroners when deciding which cases to report to the police. Currently guidance called Law Sheet No 1 from the Chief Coroner is being used to decide whether reports to the police are made. Since coroners are likely to have only seen a few cases of gross negligence manslaughter by a healthcare professional, further support from the Chief Coroner may be required prior to referral to the police. This will avoid both a lengthy and distressing police investigation in cases that do not merit referral.

**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?**

The existing high-profile cases of doctors and healthcare professionals prosecuted and convicted of Gross Negligence Manslaughter, Dr Hadiza Bawa-Garba, Mr David Sellu and Honey Rose, have all been from a BAME background. A report into cases of doctors being suspended or erased from the medical register showed that BAME doctors were more likely to be featured in this group (50% compared to 23% White and 27% unknown). In addition to this doctors in this category were more likely to have qualified outside the United Kingdom (69% compared to 31% qualifying in the UK).

GMC commissioned audits and research have revealed that there is an over-representation of BAME doctors undergoing Fitness to Practice processes. In particular BAME doctors are more likely to be referred by their employer than a patient or relative. GMC investigation statistics show that employer referrals are more likely to result in a full investigation. BAME doctors are more likely to be international graduates. They are more likely to be in locum employment and often find career progression more difficult due to difficulties in recruitment. As a result of these factors BAME doctors are also more likely to be referred to the General Medical Council.

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,

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9 General Medical Council. Analysis of cases resulting in doctors being erased or suspended from the medical register General Medical Council. 2015 [cited 2018 Jul 23]
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.

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?

The recent cases of Dr Hadiza Bawa-Garba, Mr David Sellu and Ms Honey Rose have all been against BAME healthcare professionals. This may influence the behaviours of BAME doctors who are fearful of raising concerns. Aside from BAME doctors, doctors in training may also be fearful to raise concerns as a consequence of the effects of this on high profile whistle blowers such as Dr Chris Day and Mr Edwin Jesudason.

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?

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.

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?

An inquest or fatal accident inquiry process may contain the outcomes of a route cause analysis or investigation carried out under the serious incident framework. The staff involved in the clinical incident are likely to have submitted statements to a local investigation. Often documents and reports are shared to inquests and inquiries, as are witness statements.

32. What is the role of independent medical expert evidence in inquest or fatal accident inquiry processes?

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A coroner, court or tribunal often ask for expert medical witnesses to help inform them or a jury of complex processes or procedures. They are often asked to comment on whether actions or omissions are contributory towards a death.

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?

The CPS instructs expert witnesses that are able to give evidence in a case. Often, they instruct experts who have previously worked for the CPS. It is a widely held belief that expert witnesses are hired to support a specific narrative, this often undermines confidence in them. Furthermore, there is a concern, such as that highlighted in the Williams review that ‘expert shopping’ takes place until an expert supporting a prosecution is sourced.

Our concerns are also that many expert witnesses are unaware of the legal issues surrounding GNM and their duties to the court. In the case of David Sellu, an appeal was granted partly on the basis of evidence given by an expert witness. There is no specific regulation of expert witnesses and this we feel leads to a culture where experts can be found to argue almost any position the CPS has and wishes to prosecute. Currently we know of no formal requirement for an expert witness to be trained in unconscious bias. We feel that this would be a beneficial step forwards but may not go far enough to ensure the highest quality of unfettered expert witness testimony. Independent regulation and accountability to their respective medical education colleges should be mandatory for all expert witnesses. Formal training such as that for Home Office approved Pathologists is an example of existing training that could be adapted for expert medical witnesses.

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?

We feel that the same standards and processes should apply in local investigations, fatal accident inquiries or inquests. We feel 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.

35. Are there quality assurance processes for expert evidence at this stage, if so, what are they?

We are not aware of any quality assurance processes in place for expert witnesses although we would call for an implementation of formal quality controls, scrutinised independently and reporting back to the Medical Royal Colleges. Furthermore, the conduct of expert medical witnesses should be reviewed as part of GMC revalidation by an appropriately qualified individual familiar with the provision of expert medical testimony.

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?

The Doctors’ Association UK are not aware of any formal guidance which outlines how a criminal investigation or prosecution process draws upon evidence gathered by the hospital trust or healthcare setting. Information gathered as part of a local investigation should be critiqued robustly especially when deciding about the factors involved in a death. It is expected that a local investigations is fully able to appreciate what local factors influenced
the series of events leading to a death. A robustly conducted independent review into a clinical incident could accurately inform further investigations as long as it covers all elements such as system failures and human factors. It is vital however that a safe space is created for clinicians to fully contribute to local investigations so that organisational learning and improvements can be made.

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?

The Sentencing Council have recently published new guidance for Manslaughter on 31st July 2018, it will come into effect in November 2018. It is difficult to account for the competing interests however the focus must be on achieving a just culture rather than apportioning blame in healthcare. 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.

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?

All too often system pressures and human factors considerations are downplayed in investigations. Often investigators have little or no training in human factors principles and a culture remains in the NHS where there seems to be a need to blame someone for a death. A fear of being blamed for errors results in a closed nature which doesn’t aid decision makers to make informed decisions about what learning can take place and how such errors can be prevented in the future. Investigations locally are often under resourced and as a result can be lengthy. This can negatively impact the ability for an investigation to achieve the correct outcome. At criminal level, investigations are long and reliant on expert witnesses. These expert witnesses and prosecutors should have appropriate training including that on medical error, human factors and system pressures in healthcare.

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 is a need for clear detailed prosecutorial guidance we feel does not exist currently. Guidance for the CPS on how to identify cases of true GNM, distinguish them from cases of system error and corporate manslaughter. Guidance which clarifies the bar for a gross negligence manslaughter conviction where an individual’s performance is “truly exceptionally bad” is required. The Williams review recommended the establishment of a “virtual specialist unit” to ensure only the most justified cases are prosecuted. The review recommended that a working party between the Crown Prosecution Service (CPS), Chief Coroner and medical defence societies agree on the definition of ‘truly, exceptionally bad’.

40. Why do some tragic fatalities end in criminal prosecutions whilst others do not?

It is important to note that the appropriate cases should be prosecuted. The law in Scotland for culpable homicide have the concept of mens rea or ‘guilty mind’. As a result, this 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. Deaths in healthcare following treatment are not uncommon. We must be cautious to move towards a system where clinicians are working in fear of a criminal prosecution when attempting to provide the best care for their patients. The care provided may fall short of best practice at times but often this is due to multiple factors, many of which are outside the control of a particular clinician. We therefore feel that it is a dangerous route to take to apportion blame to individuals where it can be demonstrated that there are severe system errors which may have contributed to a death. The fear among clinicians at a time where the NHS is stretched for resources and is often understaffed is that this provides the perfect storm for clinical errors and patient harm. A culture of fear and blame will exacerbate that problem further as clinicians do not feel safe to speak up and admit their errors or experiences. We would 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.

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?

It is most appropriate to consider cases involving fatal clinical incidents within the regulatory system where clinical negligence or system failures can be considered and an appropriate decision made. Furthermore, cases through the regulatory system are more likely to result in learning than cases which result in a criminal prosecution. It is important to consider whether steps have been taken by the clinician to prevent a future repeat of the situation and death. This can best be considered by a regulatory approach. We feel that the criminal system should be reserved for situations where there was a clear intent to kill or harm a patient. These cases are rare and are not typical of the high profiled GNM cases seen recently. Criminal prosecutions should be solely reserved for these rare cases in particular, ensuring that the maximum opportunity is given to actually learn rather than convict.

42. What is the role of independent medical expert evidence in criminal investigations and prosecutions?

The role of independent medical expert evidence is to inform the judge and jury about aspects of the case which are out of their usual expertise. Expert witnesses therefore enable the court to form the conclusions required to come to a verdict. The duty of expert witnesses is primarily to the court and not the instructing side. The conduct of expert witnesses is variable. As commented above, some have more knowledge of the law and legal processes than others. We 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.

These complex cases in front of a lay jury mean that the process relies heavily on the evidence provided by expert witnesses. The court expect that they will provide their opinion of the facts presented however 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.
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?

Answered above

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?

Answered above

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?

We feel that the law around involuntary culpable homicide leaves mens rea to be defined and inferred by the actions of the accused. Guidance suggests that in voluntary culpable homicide the mens rea of “criminal recklessness in the sense of a total indifference to and disregard for the safety of the public” remains an essential element. Involuntary culpable homicide is most like the law for GNM in England. The structure of legislation on involuntary culpable homicide has resulted in no convictions of medical practitioners in Scotland. We 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. In Scotland the prosecution of a healthcare professional for culpable homicide has to serve a public interest. Furthermore, it has to first be considered by the procurator fiscal and authorised by the Lord Advocate before it can proceed.

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?

The Doctors’ Association UK is seriously concerned about the actions of the General Medical Council in recent years. Of note is the recent case of Dr Hadiza Bawa-Garba whose conviction of gross negligence manslaughter resulted in suspension by the Medical Practitioners Tribunal Service. 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. As mentioned before, true patient safety advances will come by engendering an open, just culture where the focus is firmly on learning from errors.

Whilst we await the decision of the appeal next week, we are also concerned about the implications that the High Court judgement has on the future of the MPTS. In particular, the high court ruled that the MPTS wrongly reached a sanction of suspension with lower personal culpability than criminal jury. A regulatory tribunal must have the freedom and power to form its own decision upon reviewing all of the facts. In fact, an MPTS tribunal may be better placed to reach these conclusions given experience and training. We feel strongly that a tribunal such as the MPTS should be able to reach a different conclusion based on all of the evidence heard, this will enable rather than diminish public confidence, as it can be shown that all the relevant facts have been considered in reaching a decision.
We welcome the recommendations of the Williams Review which suggested that the GMC should lose its right to appeal MPTS verdicts. We feel that given recent cases this will go some way to restoring the profession's confidence in the MPTS. We feel that confidence in the GMC as a regulator has been seriously damaged as a result of the Bawa-Garba case and that the actions of the GMC in years to come will be vital in attempting to rebuild the trust of the profession.

The GMC has claimed that a conviction of gross negligence manslaughter should lead to automatic erasure from the medical register. We 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.

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?

We feel that the concept of public confidence is poorly defined by the GMC. 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. Currently, a risk remains where the same act can be treated differently. We feel that the GMC feels that it knows factors that determine public confidence, but we have not seen any robust evidence for this. 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.

We have written above about the need to avoid defensive practice. The GMC's focus on public confidence at the expense of creating an open culture of admitting and learning from errors could ultimately result in a decline in patient safety. This public confidence criterion also features when we consider the action of tribunals. The public confidence criterion allows tribunals to consider the view the public would have in a doctor’s continued practice. We struggle to see the evidence base from which this is ascertained and would call on the GMC to indicate existing research into this or commission research to fully understanding public opinion.

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?

We have seen updated guidance on reflection from a number of sources in recent months in the aftermath of the Dr Hadiza Bawa-Garba case. We would suggest that although this 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. We would advise that 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. We would further press that 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.
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 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.

51. How can the learning from a fatal incident best be shared? Should the regulator have a role in this?

Our upcoming campaign ‘Learn Not Blame’ seeks to empower individual doctors to be part of a transformational change process working towards a revolution in the culture of the NHS.

We need a culture of learning, not of blame and persecution. We need a culture of compassion and care for all who are served by it and all who work in it. A culture where mistakes and harm are prevented by openness, listening and learning. And where mistakes and harm do happen, change, not blame, is the outcome. A just culture. This is the only way we will see a real improvement in patient safety.

This campaign has been born out of a growing awareness amongst clinicians of how a toxic mix of defensiveness and concern for reputation management above all else can lead to blame-seeking culture. This is bad for doctors and worse still for patient safety.

Most patients and families, when things go wrong in healthcare, just want to know honestly what happened and make sure that the same thing never happens to anyone else. But many people face a brick wall when seeking answers from NHS organisations, and get pushed into an adversarial complaints procedure, or even litigation.

Equally, staff who raise concerns often find themselves the subject of counter-accusations, victimisation and blame, instead of having their concerns acted upon. Staff are forced into a formal whistle blowing procedure, where the ensuing legal action may bankrupt them and ruin their careers. The learning from a fatal incident can be shared on a local, regional or national level. Locally in hospitals or departments the lessons learned can be incorporated into teaching or induction programmes. Regionally, departmental conferences and patient safety conferences are key ways of sharing learning. National patient safety campaigns, communications from the GMC and other relevant national stakeholders can also help to disseminate learning.

52. Do you have any other points that you wish the review to take into account that are not covered in the questions before?

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.