MEMORANDUM OF EVIDENCE FROM THE BRITISH MEDICAL ASSOCIATION TO THE HOUSE OF COMMONS HEALTH AND SOCIAL CARE SELECT COMMITTEE

Patient safety and gross negligence manslaughter in healthcare inquiry

The BMA is a voluntary professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care.

Executive Summary

Investigating Gross Negligence Manslaughter and serious clinical incidents

- The BMA recommends that the CPS devises guidance which clarifies the application of law to Gross Negligence Manslaughter (GNM) cases in healthcare.
- Any GNM case in healthcare should only be referred to the police and CPS after consultation with the Chief Coroner (in England and Wales) to act as a final check to ensuring consistency.
- The current investigations process should be reviewed to ensure that it does not take longer than is necessary, thereby reducing stress on families and healthcare workers.
- Families must be meaningfully involved in the investigation process and be able to inform the terms of reference, comment on final report recommendations and maintain involvement to monitor action being taken to prevent a similar mistake reoccurring.
- All healthcare organisations should have a dedicated identifiable team of staff whose duties include advising on the serious incident framework and carrying out investigations. They must all be appropriately trained and experienced.
- We support the recommendations of the Williams review that the GMC should lose its right to appeal decisions of the MPTS.
- We would recommend that legal protection is provided to reflections in all education and training documents, such as e-portfolios and all annual appraisals, training forms and the Annual Review of Competence Progression.
- Members of staff involved in a serious clinical incident must have the opportunity to access professional advice and be kept properly updated on the ongoing investigation and process.
- The ultimate aim of investigations should be to shift from a culture of blame to one where staff feel confident to raise concerns, show candour, and to reflect and learn. For this to happen staff need to feel supported and be treated with compassion themselves.
- The BMA is supportive of the implementation of the Draft Health Service Safety Investigations Bill (DHSSIB) and its intention to promote system wide learning.
- We recommend that it should be mandatory for all expert witnesses to undergo core training in medico legal report writing, courtroom skills, cross examination and criminal law and procedure.
- There are significant concerns regarding racial inequalities in the NHS workforce, particularly related to BME doctors being more vulnerable to prosecution. We believe there is a need to improve BME doctors’ trust in the system by improving their treatment and addressing the inequalities and injustices that many still experience.
The BMA’s new report *Caring, supportive, collaborative: Doctors views on working in the NHS*, reveals that many doctors feel they are working in a non-supportive environment, where patient safety can at times be jeopardised and learning and reflection discouraged. The survey showed that:

- An overwhelming majority of doctors (95%) say that they are sometimes or often fearful of making a mistake
- Over half of doctors fear being unfairly blamed for errors (55%) due to system failings and pressures of the workplace
- Half of doctors (49%) practice defensively because they feel they are working in a blame culture.
- Just 40% feel they work in an environment of learning to prevent future errors.
- Over 70% of doctors believe that national targets and financial targets are prioritised over patient care.

It is clear from these findings that a new approach is needed that prioritises patient safety over top-down targets, removes barriers to collaboration and innovation, and replaces a culture of blame with a culture of learning.

1. **Gross Negligence Manslaughter and Culpable Homicide**

1.1 Currently there is no singular concept identifying when a serious clinical incident which results in a patient’s death would be categorised as potentially criminal and in need of referral to the police and Crown Prosecution Service (CPS). Because of this the BMA firmly believes that there should be an agreed explanation of the law to medical experts. This would include coroners, whose role it is to decide locally on whether to refer a case, initially to the police, and then to the CPS to make a decision on whether or not to prosecute. We recommend that the CPS devises guidance which clarifies the application of law to Gross Negligence Manslaughter (GNM) cases in healthcare and addresses the importance of giving clear instructions to expert witnesses that highlight the relevant legal tests for GNM in healthcare settings.

1.2 We would further recommend that any GNM case in healthcare is referred to the police and CPS only after consultation with the Chief Coroner (in England and Wales). This should ensure that only the cases that warrant further investigation are referred. This is vital as some medically qualified coroners may have a different threshold from a legally qualified coroner and there may be unintended bias.

1.3 Investigations can take up to 3 years with delays affecting not only those under investigation and their colleagues but also the deceased’s family who may have to wait for a very extended period before a non-prosecution decision is reached and the case can then proceed to inquest. The BMA recommends that this process should be reviewed and potentially streamlined to ensure that it does not take longer than is necessary reducing unnecessary stress on families and healthcare workers alike.

1.4 Staff must be provided with sufficient training to conduct investigations, with a focus on providing clear information for patients on process and outcomes. An early meeting should be held with the patient’s family to outline what action is being taken and expectations for the investigation.

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family representative must be involved from the outset to provide appropriate explanations to families, clarify questions for medical staff and the Trust and establish questions the family want to be asked. The Medical Examiner must also play a role in providing sufficient explanations to families. Families must be meaningfully involved in the investigation process. They must have the opportunity to inform the terms of reference, comment on final report recommendations and maintain involvement to monitor action being taken to prevent a similar mistake reoccurring.

1.5 The BMA does not itself represent doctors in fitness to practise processes. We are concerned, however, that the reasoning in the High Court judgment in the case of Dr Bawa-Garba potentially undermined the role of the Medical Practitioners Tribunal in criminal conviction cases. We are, therefore, pleased that the Court of Appeal has overturned this reasoning and agreed with our view that the Tribunal has a forward-looking role very different from that of the jury.

1.6 We oppose any presumption that a conviction for GNM should lead to erasure save in exceptional circumstances, as this would be contrary to the general principle that in determining sanction consideration should be given to all the appropriate circumstances. The sanctions guidance indicates that a tribunal, when it is considering the sanctions available, should start with the least restrictive. It also says that the Tribunal should “have regard to the principle of proportionality, weighing the interests of the public against those of the doctor”.

1.7 The BMA has consistently opposed and remains deeply concerned about the right of the GMC to appeal against fitness to practise decisions. We continue to believe that this right risks undermining doctors’ confidence in the independence and fairness of the Medical Practitioners Tribunal Service (MPTS). Fitness to practise processes are very stressful for doctors and the perception of a risk of double jeopardy can only exacerbate this problem. We support the recommendations in the Williams review that the GMC should lose its right to appeal decisions of the MPTS and that, in the meantime, GMC decisions to appeal decisions of the MPTS should involve a group or panel decision rather than lie solely with the registrar.

1.8 As with most documents, recorded reflections, such as in e-portfolios and annual appraisals, training forms and the Annual Review of Competence Progression, whether completed by a doctor or their line manager/supervisor are not subject to legal privilege. As a result, these documents might be requested by a court if it is considered that they are relevant to the matters to be determined in the case. We would recommend that legal protection is provided to reflections in all education and training documents, such as e-portfolios and all annual appraisals, training forms and the Annual Review of Competence Progression. The GMC has provided assurances both to the BMA and in public that it will never require access to a doctor’s reflection documents (or seek these from third parties such as Royal Colleges), although the doctor may provide them as evidence of remediation. We would recommend that the law should be changed to ensure that the GMC and the other regulators of health professions cannot compel the disclosure of information provided for the sole purpose of education and training.

1.9 More must be done to encourage the use of 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. It is crucial that the role of the medical examiner is clearly defined to clarify how they would integrate in local investigations.
2. **Serious clinical incidents**

2.1 Learning must be shared across and within Healthcare Organisations by Boards. Executive and non-executive directors are responsible for ensuring learning from deaths is championed and supported, leading to meaningful and effective actions that support patient safety and experience, and supporting cultural change. Team debriefs 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.

2.2 We are concerned that serious medical incidents are not currently always investigated in a timely and effective manner, with robust action plans not always properly developed and implemented and learning shared as appropriate. All healthcare organisations should have a dedicated identifiable team of staff whose duties include advising on the serious incident framework and carrying out investigations. They must all be appropriately trained and experienced. Additionally, the BMA believes that standardising local processes could lead to less cases being escalated to the criminal justice system. The BMA would also strongly advocate having clear terms or reference and information about how evidence will be gathered and what the rights of staff are.

2.3 Members of staff involved in a serious clinical incident must be given the space to gather their thoughts before they participate in any investigations and should have the opportunity to access professional advice from their relevant professional body or union, staff counselling services and occupational health services. They should also be provided with clear and timely information about the stages of the investigation and how they will be expected to contribute to the process. Discussions with Medical Defence Organisations have highlighted that many organisations do not support staff involved; indeed, in some organisations the prevailing environment is extremely unsupportive.

2.5 The ultimate aim of an investigation should be to shift from a culture of blame to one where staff feel confident to raise concerns, show candour, and to reflect and learn. For this to happen staff need to feel supported and be treated with compassion themselves. It should be mandatory for there to be two parts to the debrief sessions, with the first part offering an opportunity to receive pastoral support for the doctor involved in the serious incident and an opportunity for him/her to discuss concerns. The second part of the debrief should involve the whole team involved in the care of the patient. It is crucial that this exercise is carried out in such a way that the healthcare professionals involved feel they can have candid discussions without fear of reprisal.

2.6 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. It is 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. The BMA believes that healthcare organisations have a duty to encourage doctors to be members of a trade union and an MDO so they can get the necessary support, when needed.

2.7 A human factor training programme should be developed for everyone involved in local investigations, including prosecutors. This would lead to a better understanding of how multiple factors, such as the effect of system failures and the errors of others, can combine and affect the behaviour of a given individual. Emphasis should be on early interventions and prevention rather than cure, to identify where system problems have occurred.

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3 https://www.pointofcarefoundation.org.uk/our-work/schwartz-rounds/about-schwartz-rounds/
3. **Quality assurance for expert evidence**

3.1 We have concerns about the numbers of experts becoming very small if greater regulatory pressure is exerted, with a corresponding upwards cost pressure on the legal system as well as delays in the delivery of justice. While ideally experts should be in active clinical practice, it is also vital that robust quality assurance mechanisms are developed at every stage of the investigation. We recommend that it should be 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.

3.2 We also strongly recommend that the medical expert commissioned to carry out a local investigation is truly independent of the healthcare organisation of the doctor being investigated. It is only then that the status quo can be challenged which is critical for identifying system weaknesses and opportunities for learning.

4. **Draft Health Service Safety Investigations Bill**

4.1 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 it is 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.

4.2 We welcome the introduction of ‘safe spaces’ by the proposed Health Service Safety Investigations Body (HSSIB) which we hope will 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. We recommend 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.

5. **Race and GNM/clinical harm prosecutions**

5.1 While there is very limited data available on GNM/Clinical harm (CH) prosecutions of BME doctors compared to white doctors analysis of doctors accused of GNM based on media reports suggest that almost three-quarters of those accused between 1970 and 1999 were BME. Recent high-profile cases of BME doctors/healthcare professionals being convicted of GNM Dr Bawa-Garba, Mr David Sellu and Dr Honey Rose (although the latter two were subsequently overturned) have fuelled concerns that BME doctors are more vulnerable to prosecution.

5.2 While GMC decision-making in Fitness to Practice proceedings have not found evidence of racial bias, the GMC has explained that there are a variety of other factors that increase the likelihood

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4 House of Lords House of Commons Joint Committee on the Draft Health Service Safety Investigations Bill report, Draft Health Service Safety Investigations Bill: A new capability for investigating patient safety incidents


of doctors being complained about, investigated and sanctioned. These include: being overseas qualified; male; working in a high-risk speciality; being a locum; or being overseas-qualified which are all more strongly associated with being BME. Therefore, it is difficult to unpick to what extent ethnicity is the driver.

5.3 Another key factor is who the complaint comes from. BME doctors are more likely to be referred to the GMC by an employer and employer referrals are more likely to be investigated. We welcome the GMC-commissioned research from Roger Kline and Doyin Atewologun which will look more closely into this and we have met with Roger and Doyin and offered to assist where we can with the project.

5.4 A range of evidence points to significant racial inequalities in the NHS medical workforce. This may be down to: prejudice or unconscious bias affecting decisions; relative isolation and lack of peer support for BME doctors; and structural factors such as being recruited from overseas to jobs with poor development or progression opportunities or jobs that place BME doctors in roles or locations where there is a greater risk of failure. These kinds of reasons may increase the likelihood of BME doctors being singled out for greater scrutiny or blame when things go wrong too.

5.5 A recent BMA survey of members found that BME doctors are less likely to say that they would ‘always’ feel confident raising concerns (40% compared to 50% of white doctors) and are more likely to cite barriers to raising concerns which were related to fear and distrust in the system. For example, 57% of BME doctors said they were afraid that they would be blamed or suffer adverse consequences compared to 48% of white doctors. In addition, 48% of BME doctors said they were worried about how the information would be used compared to 38% of white doctors.

5.6 There is a need to improve BME doctors’ trust in the system and key to doing this is improving their treatment and addressing the inequalities and injustices that many still experience. The BMA held a successful race equality summit in July and we will be taking forward actions from that in the coming months.

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7 GMC, GMC commissions new research into fitness to practise referrals, 21 April 2018 https://www.gmc-uk.org/news/media-centre/media-centre-archive/gmc-commissions-new-research-into-fitness-to-practise-referrals