BMA

BMA response GMC review GNM culpable homicide

August 2018

Dear Mr Hamilton

The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

The BMA welcomes the opportunity to respond to the GMC review into how gross negligence manslaughter and culpable homicide (in Scotland) are applied to medical practice.

The BMA hopes that the review will achieve long-term cultural change, including acceptance by the leaders of healthcare systems of the importance of creating a no-blame culture. The BMA firmly believes that through the recommendations that it is advocating, it is possible to reduce the number of investigations and prosecutions and promote an open culture.

If you have any enquiries about the response or require further information, please do not hesitate to contact Reena Zapata, Senior Policy Advisor (rzapata@bma.org.uk)

Yours sincerely

Dr Chaand Nagpaul CBE
BMA council chair

Questions 1 -8 are introductory questions about the respondent

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

There is no fixed formula for deciding when negligence resulting in death amounts to the offence of gross negligence manslaughter. The doctor must be shown to have been so grossly negligent that his conduct amounted to a criminal offence. For conduct to have been negligent to that degree it must fall far below the expected standard of care or be akin to conduct that is truly exceptionally bad, and the risk of death must have been foreseeable.

Patients seek help with the aim of achieving improvements in their health and the relief of pain. A criminal act in this context is devastating to both the patient and the families involved.

Doctors in the dock, a paper[1] published in the *Journal of the Royal Society of Medicine* by Ferner and McDowell in 2006 looked at the number of doctors charged with medical manslaughter between 1795 and 2005. Ferner's and McDowell's objectives were to quantify the number of doctors charged with manslaughter in the course of legitimate medical practice, and to classify cases, as mistakes, slips (or lapses), and violations, using a recognised classification of human error system. They stated that prosecution for deliberately violating rules is understandable, but accounts for only a minority of these cases. Unconscious errors—mistakes and slips (or lapses)— on the other hand are, in their opinion, an inescapable consequence of human actions, and prosecution of individuals is unlikely to improve patient safety. They concluded that the complex systems of health care required improvement.

It is important to recognise that that most significant adverse events very often have multiple causes, many beyond the control of the individual who makes the mistake. Therefore, it may well be unfair and inappropriate to punish a person who makes an error, still less to criminalise them. The same is true of system failures that derive from the same kind of multiple unintentional mistakes. "Because human error is normal and, by definition, is unintended, well-intentioned people who make errors or are involved in systems that have failed around them need to be supported, not punished, so they will report their mistakes and the system defects they observe, such that all can learn from them. On the other hand, harm caused by neglect or wilful misconduct does warrant sanctions in health care, just as it does in other settings."[2]

The BMA also believes that death becomes a criminal act because of malfeasance where there is evidence of malicious intent to harm beyond reasonable doubt and objectively, significant and irreversible harm has been caused that should have reasonably been avoided by the practitioner.

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

The factors should always be case-specific, but must take account of all the circumstances that the defendant found himself/herself in. It is to do with how bad the breach of duty was and the state of mind of the defendant in relation to their conduct. 'Mere inadvertence' would not be punished, so the conduct has to have the requisite degree of 'badness' so as to make it a crime. The BMA remains concerned that there is not a singular concept about how bad conduct must be for it to be a

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[1] Ferner RE, McDowell SE. Doctors charged with manslaughter in the course of medical practice, 1795–2005: a literature review. J R Soc Med 2006. ;99 :309 –14

[2] Berwick report, A promise to learn – a commitment to act. Improving the safety of patients in England. August 2013.

crime, although there is greater clarity in that in *Sellu* and *Bawa-Garba*, the court have adopted the epithet of 'truly, exceptionally bad' from *Misra*.

Furthermore, the meaning of the term 'truly, exceptionally bad' is imprecise and is to be determined by a jury, rather than expert witnesses, taking into account all the circumstances. If the jury decides that the degree of negligence is indeed "truly exceptionally bad" so as to be criminal and deserving of punishment, then the defendant may be convicted of gross negligence manslaughter. Secondly, the course of conduct must cause, bring forward or at least significantly contribute to the death.

In Northern Ireland, the same common law offence as in England and Wales, is used. The Police Service of Northern Ireland will investigate, and prosecution decisions are taken by the Public Prosecutors' Service. The decision to prosecute is identical to that in England and Wales, in that 1) there should be reasonable prospects to prosecute and 2) prosecution is required in the public interest).

With culpable homicide in Scotland, we understand that there are two types: a. Voluntary, where killing was intentional; and b. Involuntary, where killing was not intentional. We are concerned with involuntary culpable homicide, which is equivalent to the offence of gross negligence manslaughter in England and Wales. The case law explains that proving the *mens rea* (guilty mind) is paramount in deciding a case of involuntary culpable homicide. Did the perpetrator possess the necessary mental state at the time of the act? The case law further explains that the mental state (*mens rea*) can be defined as: "*an utter disregard of what the consequences of the act in question may be so far as the public are concerned*" and "*recklessness so high as to involve an indifference to the consequences for the public generally*". Therefore, while it appears to be possible to convict without the *mens rea* "in relation to the death", the Scottish case law authorities clearly state that in cases of involuntary culpable homicide establishing the *mens rea* is essential.

It is important to recognise that in very high intensity immediate life threat ("maximum bandwidth") situations, is one's state of mind can become clouded by over-focussing on a task in hand resulting in loss of situational awareness and then the doctor can get into the dangerous situation of carrying on regardless instead of stopping, taking stock and revising the plan. It is something that all helicopter physicians are trained to recognise and avoid.

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?

The BMA recommends that staff should be trained sufficiently to conduct investigations which consistently provide clear information for patients on the process and expected outcomes and a list of potential questions that patients might reasonably ask.

The BMA notes that both the Serious Incident Framework and the National Guidance on Learning from Deaths in England clearly stipulate that processes for local investigation must provide patients families appropriate explanations following a fatal clinical incident, such as holding an early meeting

to outline what action is being taken and what they can expect from the investigation[3] and providing families and carers with as much information as possible in line with the Duty of Candour[4].

The BMA also 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. The medical examiner must also have a role in providing appropriate explanations to families and carers following a patient's death.

The National Guidance on Learning from Deaths states families should be informed not only of the outcome of the investigation but what processes have changed and what other lessons the investigation has contributed for the future.[5] However, despite this being outlined in national guidance, families expressed that it was not always clear what had been learned from the investigation[6] in the CQC's report, Learning, Candour and Accountability (2016).

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?

The BMA supports the National Guidance on Learning from Deaths and the Serious Incident Framework in England, which stipulates that patient's families/carers should be involved meaningfully in the investigation process, such as having the opportunity to inform the terms of reference,[7]commenting on the final report recommendations[8] and maintaining involvement after the investigation is closed for assurances that action is being taken and lessons are being really being learned.[9]

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[10]. When families were involved, they were not happy with the level of involvement.[11]

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

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[3]NHS Improvement, Revised Serious Incident Framework 2015 https://improvement.nhs.uk/documents/920/serious-incidnt-framwrk.pdf ,p.38.
[4]NHS England, National Guidance on Learning from Deaths, 2017,https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf , p.16
[5] NHS England, National Guidance on Learning from Deaths, 2017,https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf , p.19
[6]CQC, Learning, candour and accountability, 2016 https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf, p.20
[7]NHS Improvement, Revised Serious Incident Framework 2015 https://improvement.nhs.uk/documents/920/serious-incidnt-framwrk.pdf ,p.38.
[8]NHS Improvement, Revised Serious Incident Framework 2015 https://improvement.nhs.uk/documents/920/serious-incidnt-framwrk.pdf ,p.38.
[9]NHS Improvement, Revised Serious Incident Framework 2015 https://improvement.nhs.uk/documents/920/serious-incidnt-framwrk.pdf ,p.46.
[10]CQC, Learning, candour and accountability, 2016 https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf, p.15
[11]CQC, Learning, candour and accountability, 2016 https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf, p.18

the investigation may not have seen[12] .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. There is also a role for professionally supported resolution for emotional aspects of the incident for the family, which should be bespoke to their needs. This would be based on early encounter and assessment with professionals.

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?

This should be part of the professional and statutory duty of candour. Where the death is not an unexpected one then there are organisations that help with bereavement counselling. Assuming candid conversations are taking place then a meaningful dialogue should be taking place. Some situations may benefit from mediation – but that assumes that there must be a complaint, which is not always the case so it may not always be clear when mediation will be effective and helpful. For example, if there is the contaminant of contingency fee-based litigation in the equation, mediation is not always useful.

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. Occasionally, discussions with teams may need to happen first to provide consistent and accurate answers. 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.

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

The BMA agrees with the key principles set out in the national guidance on learning from deaths including: providing bereavement support for families and carers of people who die under their management and care; bereavement advisors to manage practical aspects following the death of a loved one; and support during and following an investigation.[13]

The services and support highlighted in the Serious Incident Framework must be standardised so they become available in all the nations. The framework makes it clear that all staff involved with and supporting bereaved and distressed people must have the necessary skills, expertise, and knowledge of the incident in order to explain what went wrong.[14] However it is clear from the CQC's report that staff are often not given the appropriate training to deal with these situations.[15]

The BMA notes the recent publication of 'Learning from deaths: guidance for NHS trusts on working with bereaved families and carers' by NHS England[16]. This outlines the level of support required for

[12]CQC, Learning, candour and accountability, 2016 https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf, p.17

[13]NHS England, National Guidance on Learning from Deaths, 2017,https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf , p.17

[14]NHS Improvement, Revised Serious Incident Framework, 2015 https://improvement.nhs.uk/documents/920/serious-incidnt-framwrk.pdf ,p.38.

[15]CQC, Learning, candour and accountability, 2016 https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf, p.19

[16] NHS England, Learning from deaths: guidance for NHS trusts on working with bereaved families and carers, 2018 https://www.england.nhs.uk/wp-content/uploads/2018/07/learning-from-deaths-working-with-families.pdf

bereaved families and carers in terms of the bereavement pathway, information for families and the family liaison service, while identifying good practice for local services.

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

The BMA recommends that the following should be implemented to ensure lessons are learned from investigations:

- Healthcare organisations should ensure that any recommendations made following an investigation, once implemented, are routinely followed up and assessed in practice.
- 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.
- It would be useful to use scenarios based on past incidents as training exercises within Healthcare Organisations, and also as training for medical students.
- A just culture should be developed in each Trust, where every member of the healthcare team, regardless of their status or role, is openly encouraged to look routinely for better ways of doing things and is made to feel comfortable offering suggestions for improvement. By focusing on achieving excellence, many basic errors could be avoided in the first place, and a culture emerges where how things are done is routinely discussed. This would make any discussions about possible errors that might arise, easier to have.
- The BMA supports the views that bereaved families and carers can offer an invaluable source of insight to improve clinical practice, and that their concerns should inform decisions about the need to undertake an investigation[17] The BMA recommends that meaningful involvement of patients' families in actions plans and service improvement following investigations would ensure lessons are learned.
- 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.[18] Team debrief following serious clinical incidents, such as using Schwartz Rounds[19] for departmental learning and support of staff must be implemented regularly to ensure lessons are learned.

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?

Lack of consistency

The current arrangements are not clear and consistent. We are aware that many healthcare organisations do not have identifiable staff members whose responsibilities include investigating patient safety incidents. The BMA is concerned that serious incidents are currently not always investigated in a timely and effective manner, with robust action plans not always properly

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[17] NHS England, National Guidance on Learning from Deaths, 2017, https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf , p.16

[18] NHS England, National Guidance on Learning from Deaths, 2017, https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf , p.23

[19] https://www.pointofcarefoundation.org.uk/our-work/schwartz-rounds/about-schwartz-rounds/

developed and implemented and learning shared as appropriate. The BMA believes that 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. In this regard there may be a role to play for the proposed Health Service Safety Investigations Body (HSSIB) in identifying where processes work well and promoting these approaches across all trusts. We do not, however, believe that the HSSIB should be granted the right to accredit trusts to undertake investigations themselves, which may result in conflicts of interest. 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.

Freedom to speak

We 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.[20]

Interference by the management of the healthcare organisation

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. 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. Such attitudes can be unhelpful for doctors who are trying to do what their professional duty requires. The BMA believes it is important to recognise all the factors that influence the values and day-to-day behaviours of people working in the healthcare sectors. The ultimate aim is 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.

A serious incident framework will only operate effectively in an environment where staff are confident their organisation has a just culture and they will be treated fairly and reasonably.

Duty of candour

The principles of openness and honesty as outlined in the NHS Being Open guidance and the NHS contractual Duty of Candour[21]must be applied in discussions with those involved. This includes staff and patients, victims and perpetrators, and their families and carers. Being open and transparent, involve expressing sincere apologies and explaining when things go wrong. A thorough investigation should also be conducted to ensure that patients and their families are satisfied that lessons will help prevent the incident from happening again. It is also vital that healthcare organisations put emphasis on the fact that saying sorry is not an admission of liability.

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[21] http://www.cqc.org.uk/sites/default/files/20141120_doc_fppf_final_nhs_provider_guidance_v1-0.pdf

Support for doctors involved in the serious incident

It is vital to recognise that serious incidents can have a significant impact on staff who were involved in the incident. Like victims and families, they will want to know what happened and why and what can be done to prevent the incident happening again. Staff involved in the investigation process 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. "Provider organisations should make it clear that the investigation itself is separate to any other legal and/or disciplinary process. Organisations must advocate justifiable accountability but there must be zero tolerance for inappropriate blame and those involved must not be unfairly exposed to punitive disciplinary action, increased medico-legal risk or any threat to their registration by virtue of involvement in the investigation process."[22]

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 from their employer.

Role of colleagues investigating the serious incident

The BMA recommends that all the nations adopt the following protocols as outlined in the serious incident framework, it is essential to identify team members with:

- Knowledge of what constitutes an effective systems investigation process, and the skills/ competencies to lead and deliver this;
- Skills/ competencies in effective report writing and document formulation;
- Expertise in facilitating patient/family involvement
- Understanding of the specialty involved – this often requires representation from more than one professional group to ensure investigation balance and credible;
- Responsibility for administration and documentation (or for there to be adequate administrative and IT support);
- Knowledge/ expertise in media management and a clear communication strategy – or access to this specialist support via the organisation's communications team
- Access to appropriate legal and/or information governance support where appropriate;
- Access to competent proof-reading services where required; and
- Appropriate links/mechanisms to share lesson locally and nationally during the investigation as required[23]

[22] Serious Incident framework: Supporting learning to prevent recurrence, NHS England
[23] Serious Incident framework: Supporting learning to prevent recurrence, NHS England

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 BMA believes that a human factors training programme should be developed for everyone involved in local investigations. This would lead to a better understanding of how multiple factors (which often exist in complex clinical settings) such as the effect of system failures and the errors of others can combine and affect the behaviour of a given individual. That may help those involved in the prosecution process to assess if there is any real criminal culpability on the part of the doctor. The focus should not be on finding someone on whom to fix the blame while ignoring the system that caused the incident. We would recommend that a mandatory human factors training programme is developed for everyone involved in local investigations.

The existing Healthcare Safety Investigation Branch (HSIB) and the proposed HSSIB will take a view when reporting as to the impact of multiple factors, which may include issues such as workforce. This approach allows for system level learning rather than a focus on apportioning blame to an individual, we believe that this provides a good model for how a 'root cause' analysis should be undertaken.

Additionally, 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.

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 great deal of variability in who is involved in conducting investigations following a serious clinical incident. In some places it is a matron and a clinical director, in others a consultant and senior nurse/matron. While that variability in respect of who is involved in conducting those 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.

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

As far as the BMA is aware, 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.

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

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.

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

A degree of variability relating to measures to ensure the independence and objectivity of local investigations, with some healthcare organisations having formal processes in place and not. Additionally, the measures taken to ensure the independence of local investigations need to address the conflict of interests with the case investigators.

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

There is currently no independent medical expert in local investigations - the medical expert is often already part of the team, employed by the healthcare organisation. As such, this can create a conflict of interest between the employer and the medical expert. We would strongly recommend that the medical expert commissioned to carry out the 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. Furthermore, demonstrating that an investigation will be undertaken objectively will also help to provide those affected (including families/doctors involved in the care of the patient) with confidence that the findings of the investigation will be robust, meaningful and fairly presented.

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?

The BMA does not believe that they are not independent for internal inquiries. However, if questions 22 and 23 refer to investigation by the police and not local investigation by the Healthcare Organisation our answer to question 22 would be that the role of the independent medical expert is critical, but we are unsure how they are selected beyond potential word of mouth. Medical experts by and large do not have training in unconscious bias.

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

Apart from whole practice appraisal and providing evidence of being up to date, there is little quality assurance process for experts. 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 eyes of the purchaser. A good expert applies the correct legal tests correctly and writes in a clear and concise manner. They express probabilities with confidence, or the lack of certainty with clarity. We would have concerns about the numbers of experts becoming very small if greater regulatory pressure was

exerted, with a corresponding upwards cost pressure on the legal system as well as delays in the delivery of justice. Ideally though, experts should be in active clinical practice.

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)

We have already responded in the patients' section.

As outlined previously in this response we believe that if the proposed HSSIB succeeds in its aim to identify system wide learning, it will create an opportunity to promote best practice and learning from both its own investigations, and those undertaken by other organisations and regulators, across the health service.

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?

The BMA is not aware of anything formal, other than peer to peer support. The BMA however provides confidential emotional support to all doctors going through GMC Fitness to Practise investigations through the Doctor Support Service. This is peer support delivered by doctors experienced in helping colleagues. The support is provided over the phone, as well as face to face at hearings if appropriate. All doctors are notified of the Doctor Support Service at the beginning of an investigation process. BMA membership is not required. The BMA Counselling and the Doctor Advisor Service offer confidential emotional support to all doctors and medical students, again regardless of BMA membership. They would available to doctors around such incidents where the GMC is not involved.

Whilst the BMA recognises the need to provide emotional support to those who are alleged to have made egregious errors there are few other resources provided for doctors.

There is a wealth of literature on the issues doctors face as patients, and how reluctant they are at recognising support is needed. For example, in 'Doctors as patients', Ed Petre Jones states that "Doctors don't like being on the "wrong" side of the doctor-patient divide. Faced with this prospect their objectivity often crumbles. Some reach for recherché diagnoses at the first hint of illness; many more ignore or downplay their health problems."[24]

Second Victim

Additionally, it is important to recognize the concept of 'second victim'. A second victim is a healthcare provider involved in unanticipated adverse patient event, medical error and/or a patient related injury who becomes victimized in the sense that the provider is traumatized by the event. Frequently, second victims feel personally responsible for the unexpected patient outcomes and feel as though they have failed their patients, second-guessing their clinical skills and knowledge base.[24]

'Recognising the harmful effects that adverse events have on those in providing clinical care, the term 'second victim' has been used. This is a useful concept and helps us to understand why such events can be incredibly stressful to deal with, sometimes leading to prolonged stress and affecting an individual's health, ultimately impacting on professional and family life.'[25]

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[24] Scott SD, Hirschinger LE, Cox KR, McCoig M, Brandt J, Hall L. The natural history of recovery for the health care provider "second victim" after adverse patient events. Qual Saf Health Care. 2009;18:325-330

[25] Dr Mike Devlin, Head of Professional standards and Liaison at the MDU.

Mistakes can and do happen in modern medicine and although it is often said that "doctors are only human," technological wonders, the apparent precision of laboratory tests, and innovations that present tangible images of illness have in fact created an expectation of perfection. Patients, who have an understandable need to consider their doctors infallible, have colluded with doctors to deny the existence of error. Hospitals react to every error as an anomaly, for which the solution is to ferret out and blame an individual, with a promise that "it will never happen again."[26] In the absence of mechanisms for healing, doctors can find dysfunctional coping mechanisms such as seeking solace in alcohol or drugs. Furthermore, they often respond to their own mistakes with feelings of anger and projection of blame and may act defensively.

The BMA's remit excludes representation at GMC hearings however there will be cases where it is appropriate for both the BMA and the Medical Defence Organisations (MDOs) to be involved due to the nature of the individual case (e.g. where a mixture of clinical and non-clinical allegations) In certain circumstances, in addition to a GMC case, an employer may pursue a matter related to an employment issue. We therefore encourage our members to liaise with us and their MDOs at the earliest opportunity. This continuity of support is crucial. MDOs will approach the BMA regarding advice on process/procedure and contractual matters for the individual member. Additionally, we will provide advice, support and representation related to specific grievances that the member may wish to pursue related to the actions of their employer-this may include potential claims related to bullying, harassment, discrimination. If matters are not resolved through the employers' internal process then, subject to securing sufficient merit, these claims are referred to Industrial Tribunals by the BMA's independent legal provider.

With regards to specific support from the MDOs, a medico-legal adviser may have been personally supporting a doctor from the first time they phoned the MDO, through local procedures (exclusion, etc) through to those cases that go on to inquests, criminal investigations and the GMC. Because the support to members is usually by doctors, it is provided by those with a clinical background who understand the stresses doctors face and can give them the opportunity to discuss their fears.

The BMA believes that healthcare organisations have a duty to encourage doctors to be members of a trade union and an MDO. This is even more pertinent to doctors who would otherwise 'fall through the net' resulting in devastating consequences.

Educational support in terms of remediation is very variable and often down to the doctor to pursue or initiate it.

The National Clinical Assessment Service (NCAS), which operates in England, Wales and Northern Ireland was originally identified as one such body which might contribute to patient safety by helping to resolve concerns about the professional practice of doctors, dentists and pharmacists. NCAS provides expert advice and support, clinical assessment and training to the NHS and other healthcare partners and works to resolve concerns about the practice of dentists, doctors and pharmacists.

The BMA recommends that Assisted Action Plans, which NCAS used to provide to employers and individual doctors during disciplinary proceedings, should be reinstated. The emphasis of these documents was on trying to keep doctors at work wherever possible.

With regards to how the support could be improved, the BMA is investigating the possibility of developing local coaching and mentoring provisions. We should also recognise that doctors who are

[26] Albert W Wu, Associate Professor, Medical Error: the second victim, BMJ, March 2000

being investigated would usually have been suspended by their employer and as such could face financial problems. We are aware that the Royal Medical Benevolent Fund offers financial assistance and advice to doctors who may be in hardship and unable to pay for legal or practical support.

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?

Currently the process often starts with the coroners referring the cases to the police who then escalate the matter to the Crown Prosecution Service (in England and Wales) for a decision on whether to charge. The role of the coroner is to look at 'who, how and why the death occurred'. As this is a local service, there are differences in the way GNM cases are dealt with. It is crucial that there is a consistent approach by coroners in relation to all GNM cases in healthcare that they refer to the police. We would recommend that any GNM cases in healthcare are referred only after consultation with the Chief Coroner (in England and Wales). This should ensure that only the cases that warrant further investigation are referred to the police. This is vital as some medically qualified coroners may have a different threshold from a legally qualified coroner and there may be unintended bias.

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 is very limited data available on GNM/CH by protected characteristic. The CPS recently provided data to the Williams Review which gave numbers of GNM cases involving healthcare professionals. We believe this is the first time such information has been put in the public domain. However, CPS have not provided a breakdown by ethnicity or place of primary qualification. The BMA has requested this information from the CPS as we believe it is vital to understanding whether ethnic or national origin could be a factor in GNM/CH investigations and prosecutions and what action could be taken to address any differences in treatment.

Professor Robin Ferner published an analysis of doctors accused of GNM, which was based on media reports, in the BMJ in 1999. It found that almost three-quarters of those accused between 1970 and 1999 were of South Asian, South East Asian or African origin, which suggests a significantly greater likelihood of Black and Minority Ethnic doctors being investigated and charged. The recent high-profile cases of BME doctors and healthcare professionals being convicted of GNM – Dr Bawa-Garba, Mr David Sellu and Dr Honey Rose (although the latter two were subsequently overturned) – have also fuelled concerns that while GNM investigations and prosecutions are very rare, some groups are more vulnerable. There is also a disproportionate representation of BME doctors and doctors who qualified overseas in GMC fitness-to-practise referrals, investigations and sanctions, which adds to a sense of increased vulnerability linked to ethnic or national origin.

The GMC has commissioned various research studies to assess the fairness of FtP processes and to understand the over-representation of BME doctors. Audits of GMC decision-making in FtP proceedings have not found evidence of racial bias. The GMC has reported to us that there are a variety of other factors that also increase the likelihood of doctors being complained about, investigated and sanctioned, such as being male, working in a high-risk speciality, being a locum, or being overseas-qualified which are more strongly associated with being BME. Therefore, it is difficult to unpick to what extent ethnicity is the driver and to what extent the increased risk can be explained by other factors. One study that adjusted for other personal or complaint-related

characteristics found that ethnicity did not drive the increased risk of high impact outcomes but being overseas-qualified did (although a majority of those who are overseas-qualified are also BME).

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. It is therefore welcome that the GMC has commissioned new research from Roger Kline and Doyin Atewologun to try and understand what is happening within NHS organisations that is driving the over-representation of BME doctors (or under-representation of white doctors) in employer disciplinary proceedings and GMC referrals.

A range of evidence points to significant racial inequalities in the NHS medical workforce. BME doctors have lower success rates in medical education, training and recruitment, are more likely to experience discrimination or bullying and harassment, are more likely to be disciplined by employers, are less likely to progress to senior levels and are less likely to receive clinical excellence awards. There are likely to be multiple reasons behind these differences, which may include: experiencing bias or prejudice from others; feelings of isolation and difficulty accessing networks of support; feelings of stereotype threat that erode confidence and cognitive ability; 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 also increase the likelihood of BME doctors being singled out for greater scrutiny or blame when things go wrong.

GNM investigations and prosecutions of doctors bring together the NHS and criminal justice system. The recent government-commissioned Lammy review highlights a wide range of racial disparities in the criminal justice system too. These include higher rates of charging, differences in plea decisions, harsher sentencing, worse treatment in prison and an increased likelihood of reoffending for BME people. The review notes, however, that CPS decisions on whether to charge were proportionate, concluding that “In most cases, defendants’ ethnicity does not affect the likelihood that they will be charged by the CPS”. It pointed to a range of other factors in the wider criminal justice system and society that combine to explain the increased risks and worse outcomes for BME people that need to be addressed.

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?

A recent BMA survey of members found that most would ‘always’ or ‘sometimes’ feel confident raising concerns about patient care in their place of work. However, BME doctors were less likely to say that they would ‘always’ feel confident raising a concern – 40% of BME doctors said they would, compared to 50% of white doctors. In addition, BME doctors were nearly twice as likely to say they would not feel confident raising a concern as white doctors – 14% compared to 8%.

There are a variety of barriers which might prevent doctors from raising concerns. The most common reason given by respondents to the BMA survey was: workload pressure makes it difficult to find the time to report concerns – 59% of both white and BME doctors gave this response. Similar proportions of white and BME doctors also said that they were discouraged by the lack of feedback on concerns raised (46% white, 47% BME) and the same proportions of white and BME doctors (9%) said they would not be sure how to report a concern. The most significant differences in responses by ethnicity reflect higher levels of fear and distrust in the system among BME doctors. In particular,

BME doctors were significantly more likely than white doctors to say that they were afraid that they would be blamed or suffer adverse consequences if they raised a concern (57% BME, 48% white) and that they were worried how the reports would be used (48% BME, 38% white). BME doctors were also more likely to say that there was a lack of commitment to learning lessons from errors or incidents (41% BME, 33% white).

The recent high profile GNM investigations and prosecutions against BME doctors, the over-representation of BME doctors in complaints to the GMC and FtP investigations, the over-representation of BME doctors in employer disciplinary proceedings, and wider racial inequalities, such as the increased likelihood of BME doctors experiencing bullying, harassment or discrimination at work, are all likely to contribute to the higher levels of fearfulness and distrust expressed by BME doctors. Removing the additional barriers faced by BME doctors will depend on effective action being taken to eradicate racial inequalities and discrimination in the NHS so that BME doctors can be confident that they will be treated fairly.

On 11 July 2018, the BMA hosted a race equality summit, 'Creating a turning point for race equality in medicine', which engaged with a wide range of BME doctors, race equality experts and key stakeholders. The discussions were constructive and focused on what needs to change to create a genuinely fair and inclusive profession and NHS. We hope to share a draft action plan with stakeholders shortly. In the meantime further information about the summit can be found here.

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?

Investigations are often lengthy and can take as long as three years. In the process, the doctor affected is under a great deal of stress and a NHS system that is already strained may be denied the services of that particular doctor. Furthermore, as there is no dedicated police unit dealing with GNM cases in healthcare, this has a direct impact on the length of time the investigation takes. If a national police unit is established to investigate GNM cases in healthcare, it would ameliorate the process and reduce delays. The benefit would be that investigations would be processed promptly, reliably and consistently. We would also encourage early liaison between the police and the CPS in England and Wales, the Crown Office and Procurator Fiscal service in Scotland and the Director of Public Prosecutions in Northern Ireland. This would ensure that only the cases which warrant prosecution are progressed.

In Scotland, we are aware that the Crown Office and Procurator Fiscal Service, like the NHS, is overwhelmed. As such, there is a risk of the system dealing poorly with individuals as a result in both services. The Fiscal Service needs the resources to investigate and to respond in a timely manner to all parties in this situation.

We would recommend that a national police unit is established in England to investigate GNM cases in healthcare. The benefit would be that investigations would be processed promptly, reliably and consistently. We would also encourage early liaison between the police and the CPS. This would ensure that only the cases which warrant prosecution are progressed.

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?

The processes are likely to be linked in that statements from staff involved will usually be requested by, and provided to, the coroner. The same staff are very likely to have been involved in local investigations into what went wrong. In addition, relevant records will also be provided, and these will usually be the clinical records, but could also include local investigation materials, such as one carried out under the Serious Incident Framework. Similar processes apply to FAIs in Scotland.

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

A court or tribunal will often require expert evidence to help it understand why something was done and whether an act or omission was reasonable in the circumstances.

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 selects the relevant expert witness from the different registers of experts, the police registers or via recommendations. From a practical point of view, the CPS may find it helpful to be able to instruct experts with whom they have previously worked and whom they believe are reliable. The BMA is aware that the police also instructs experts too in these cases. The BMA firmly believes that the experts used should be truly independent.

The expert is obliged through the Civil Procedure Rules to provide objective, unbiased opinion on matters within their expertise and their duty is to the Court and not to the person from whom they receive instructions (Criminal Procedure Rules 33.2). However, the BMA believes that more should be done in practice to ensure that expert evidence is impartial, objective and aids justice.

Participants at a joint BMA/CPS/Royal Society of Medicine (RSM) workshop in October 2017 highlighted that there was inconsistency in instructions to experts. The BMA firmly believes that there should be an agreed position from all parties about an explanation of the law to experts. We continue to recommend that the CPS devises guidance which clarifies the application of law to 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.

In highly specialised industries such as medicine, aviation, forensics and policing, the performance of the expert is critical. Defining expertise and who is an expert has been a complex and challenging task with a variety of views and disagreements[27]. One crucial element of the performance of the expert relates to biasability and reliability. 'Biasability refers to the ability to make decisions based on relevant information without being biased by irrelevant contextual information. Reliability refers to how consistent and how reproducible expert decision making is even when there is no exposure to irrelevant biasing information.'[28]

Common cognitive biases that are part of human nature and may affect decision-making include: confirmation bias (when people seek, weigh or interpret evidence to confirm a pre-existing belief or assumption); contextual bias (when information about the surrounding context influences reasoning

[27] Feldon, D. F. (2007). The implications of research on expertise for curriculum and pedagogy. Educational Psychology Review, 19(2), 91–110.
[28] Hierarchy of Expert Performance Itiel E. Dror, Journal of Applied Research in Memory and Cognition

but is logically irrelevant to the decision at hand); and unintentional stereotype bias (when people interpret certain traits as associated with a particular social group, race, or gender). Whilst such biases may be part of human nature, it is crucial to understand how they may influence decisions and to guard against them in expert witness work where there is a fundamental requirement for objective evaluations and interpretations. 'The consequences of cognitive bias may be far-reaching: decisions by the investigator to follow a particular line of enquiry, the CPS to prosecute or not, and decisions in the criminal justice system as to the guilt or innocence of an individual upon which may rest their liberty or even their life in some jurisdictions, frequently depends on the reliability of the evidence and the conclusions drawn from its interpretation.'[29] The BMA believes that it would be beneficial for everyone involved in the prosecution process to receive effective training on cognitive bias and how to guard against it.

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?

The same point applies here as applied to inquests. If it is relevant, a criminal investigation may seek disclosure of a local investigation report and possibly the documentation associated with that. The crucial point is that they are focussed on providing objective and impartial opinion, and that usually means they need to go to primary sources: clinical records and witness statements from those involved.

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

We are not aware of quality assurances mechanisms available at this stage. Experts who do not perform as well as they should will often find that they do not get instructed again. Therefore, although they are not subject to quality assurance in a traditional sense, most experts will work hard to ensure that they do provide a quality, professional service. It is vital that robust quality assurance mechanisms are developed at every stage of the investigation.

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?

Although the BMA does not know about the extent to which criminal investigation draws on the evidence gathered in the post incident investigation, we continue to firmly believe that there needs to be a more consistent approach in criminal investigations at a local level, and in decisions taken by prosecutors.

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?

This is clearly set out in the CPS full code test. The code considers that a number of factors are important in deciding upon prosecution. These factors include (a) that the offence is serious; (b) the individual's involvement is significant and premeditated and/or planned; (c) the circumstances of the victim (or patient) indicate particularly vulnerability as in the case of a vulnerable adult or child or there is any kind of discrimination; (d) the impact of the offence on the public; (e) whether

[29] Cognitive Bias Effects, Forensic Science Regulator, Guidance, p 10

prosecution is proportionate to the outcome and (f) whether the cost and value of the prosecution is proportionate to the likely outcome and public benefit.

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?

Investigations are often lengthy and can take as long as three years. The BMA continues to be very concerned that at each stage, decisions are taken in an inconsistent environment. Furthermore, it is our opinion that insufficient resources are allocated to investigations at a local level. Once findings reach a criminal level of significance, then there may well be sufficient resources. It is crucial that medical experts are instructed early and that early liaison with the CPS Special Crime Division, is established. We would recommend that prosecutors have human factors training, because as the question implies various factors can contribute to an unexpected death, and not all of them are within the control of those subject to criminal investigation. Additionally, experts need to be properly instructed, to ensure they understand their duty to be impartial and they need to have a proper understanding of the law of gross negligence manslaughter.

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)?

We do not believe that key decision makers and/or prosecuting authorities have necessary support to make fully informed decisions, and as a result this could lead to errors of judgement which will be unfair to the doctors concerned. There is a need for detailed prosecutorial guidance. It is crucial that engagement with the CPS Special Crime Division in all GNM cases involving healthcare staff, is carried out early. They have the experience to understand the complexities of GNM in a medical setting. Further, the existing Senior Investigating Officer guidance about this type of investigation is out of date and limited in some areas.

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

In England and Wales, the role of the coroner is crucial here. Fatalities following clinical treatment are not uncommon. Sometimes death occurs due to the natural disease process and the treatment was simply futile. Sometimes the treatment given was negligent, but not seriously so and not 'truly, exceptionally bad'. Sometimes the treatment was negligent, but that treatment did not actually cause the death. Guidance to coroners to ensure they only refer cases to the police where it is appropriate to do so is needed.

The BMA believes that political and media interference can also influence the decision as to whether, it is necessary to initiate a criminal prosecution.

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 more appropriate for fatal clinical incidents to be considered in the regulatory system than in the criminal system as a general norm. We agree with the view expressed by Don Berwick in his review of patient safety 'A promise to learn - a commitment to act' (2013) that legal sanctions are appropriate only in "the very rare cases where individuals or organisations are unequivocally guilty of wilful or reckless neglect or mistreatment of patients" (p. 33). In general, individuals are not to

blame for patient safety problems and, where individuals are to some extent responsible, the public is likely to be much better served through the forward-looking process of determining whether fitness to practise is impaired and, if so, what sanction should be imposed than through a criminal trial. The former can take account of remediation and is much more likely to be consistent with a transparent learning culture.

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

The primary duty of the expert witness is to the court, not to the party that has instructed them. For expert evidence to be admissible it needs, among other things, to provide the court with information that would be outside the judge's or jury's knowledge and experience, and it must give the court the help it needs to form its conclusions.

The BMA recommends 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. Whilst Royal Colleges might be able to develop training, the relevant parts for expertise in GNM are not college specific and are currently provided by a range of commercial and competitive providers, some with external quality assurance oversight. For example, the Cardiff University Bond Solon Expert Witness Certificate (CUBS) is a comprehensive assessed training programme which equips delegates with the necessary competencies and confidence to work effectively as an expert witness.

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?

Same answer as question 33.

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?

Same answer as question 34.

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

Same answer as question 35.

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?

Although there are differences in law between culpable homicide in Scotland and gross negligence manslaughter in England, the BMA believes that the key issue is the different approaches taken by procurators fiscal in Scotland and coroners in England.

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 BMA does not itself represent doctors in fitness to practise processes. We are concerned, however, about the implications of the recent judgement of the High Court in the case of Dr Bawa-

Garba, who was convicted of gross negligence manslaughter and then suspended by the Medical Practitioners Tribunal Service. Following an appeal by the GMC, the High Court decided in this case that the Medical Practitioners Tribunal did not give sufficient weight to the verdict of the jury and was wrong to conclude that public confidence in the profession could be maintained by a sanction short of erasure. The Court found that the Tribunal, "as a result of considering the systemic failings or failings of others and personal mitigation which had already been considered by the jury", wrongly reached a less severe view of Dr Bawa-Garba's personal culpability than the jury. The BMA is concerned about the extent to which the court's judgement could restrict the ability of a Medical Practitioners Tribunal to form its own view of the facts and of any public confidence considerations in cases involving a criminal conviction.

We would oppose any presumption that a conviction for gross negligence manslaughter should lead to erasure save in exceptional circumstances. 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".

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. Also, given Williams' view that the impact of the right of appeal on doctors' engagement with the GMC has deterred reflection and learning from errors to the detriment of patient safety, we would expect the GMC to be extremely cautious about making any decisions to appeal.

We welcome the recommendation of the Williams review that the Professional Standards Authority (PSA) "should review whether the outcome of fitness to practise procedures is affected by the availability of legal representation for registrants" and would like to see the GMC and/or MPTS do the same. We have a particular concern about the impact on unrepresented doctors of the move to replace legal assessors, who provide legal advice to fitness to practise tribunals, with legally qualified chairs. Discussions with legal assessors are particularly important for unrepresented doctors so that they understand the proceedings and the relevant considerations for the panel at various stages. However, even unrepresented doctors now get legal assessors only in exceptional circumstances.

We believe that the MPTS should appoint a legal assessor in all cases involving an unrepresented doctor. We would recommend that the PSA and the GMC/MPTS should review whether the outcome of fitness to practise procedures is affected by the availability of legal representation for registrants.

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 have previously expressed concern that the public confidence criterion could lead to 'trial by media' and called for guidance that properly relates 'public confidence' to the GMC's overarching objective of public protection. One particular problem with the criterion is the subjectivity of public confidence considerations, which can lead to the same act being treated differently in different cases depending on the extent to which the patient is harmed. We would like to see research into the question of what members of the public would really expect in cases involving clinical error. (The PSA report 'Dishonest behaviour by health and care professionals: Exploring the view of the general public and professionals' (2016) illustrates the ability of members of the public to take a nuanced view in relation to cases involving dishonesty.) We would also suggest that any use of the public confidence criterion should be with reference to the perceptions of a citizen who is well-informed about the issues raised by the case.

We note that reliance upon the public confidence criterion may, if it results in outcomes that are too severe, have consequences which are contrary to the public interest, such as encouraging defensive practice, discouraging remediation, candour and openness as the best means of promoting patient safety, and deterring new entrants to the profession. We also note, however, 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. We would recommend that the use of the public confidence criterion in cases involving clinical error should be reviewed and that further research into what members of the public would really expect if fully informed in such cases should be conducted.

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 believe 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. With regards to the Annual Review of Competence Progression (ARCP), the reflective requirements could be amended so that they can be met in a range of ways and not just through written reflections. A clear distinction should be drawn between everyday reflections and reflections on clinical incidents.

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. A doctor can also choose to disclose their reflective statements as part of their defence, in court or tribunal proceedings, to support their case and show how they have responded to an

incident. It should also be noted 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[30].

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. 81 per cent of respondents to Dr Vaughan's survey [31]have stated that this potential access affects the way they currently record their reflections. It is crucial that doctors' personal reflections, which encourage openness and improvement through reflection and learning, are protected. The focus of reflection should be on learning, rather than what has gone wrong. 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.

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?

The BMA recognises 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.

The BMA provides confidential emotional support for doctors going through GMC fitness to practise investigations through our Doctor Support Service. The support is delivered by doctors who are experienced in helping colleagues. It is primarily given over the phone with an optional element of up to two days face to face support at a hearing. Doctors are notified about this service at the beginning of an investigation process. BMA membership is not required. A doctor may also contact either BMA Counselling or our Doctor Advisor Service (see our response to question 26).

As previously indicated 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.

[30] http://www.legislation.gov.uk/nia/2016/4. 32 (1) **Privileged and confidential information**

[31] i Developed by Dr Jenny Vaughan (Consultant Neurologist, Imperial College Healthcare NHS Trust)

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

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. An important point in Don Berwick's review of patient safety 'A promise to learn - a commitment to act' (2013) is that in general NHS staff are not to blame for patient safety problems: "in the vast majority of cases it is the systems, procedures, conditions, environment and constraints they face that lead to patient safety problems" [32](p. 4). We might reasonably expect that, if staff know they are not going to be unfairly blamed for incidents, the learning from those incidents is likely to be shared more effectively.

Additionally, 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**.**

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

<u>The role of the jury</u>

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.

<u>The role of management</u>

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.

<u>Other experts</u>

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[32] Berwick report, A promise to learn – a commitment to act. Improving the safety of patients in England. August 2013.

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.

The role of the medical examiner

It is crucial that the role of the medical examiner is clearly defined to clarify how they would integrate in local investigations.

Upstream regulation

The BMA would 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.

Reporting incidents

Although question 51 concerns how learning from a fatal incident can best be shared, and the regulator's role in this, it is also important to ensure that openness and transparency is protected where doctors believes that a mistake has been made that is not linked to a fatal incident, so that lessons are learned and mistakes not covered up.

All trusts/health boards are mandated to provide mechanisms for reporting incidents or any event which has given rise to potential or actual harm or injury, to patient dissatisfaction or to damage/loss of property. In England and Wales, reports are also collated centrally through the National Reporting and Learning System, with over 4 million reports submitted since its introduction in 2003. Similarly, under the 2016 junior doctor contract in England exception reporting systems are required which enable trainees to identify when working beyond rostered hours, miss safety breaks or are missing educational opportunities. In Scotland, Northern Ireland and Wales (and under 2002 junior doctor terms and conditions in England) a process called rota monitoring is used to identify issues around working beyond safe limits. In Wales a Learning Contract has also been established to identify when educational opportunities are not being delivered for trainees. These mechanisms are important in identifying when staff are working in conditions that may well be unsafe or when mistakes occur.

We know 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.