

Statement:

Marx Review into the use of Gross Negligence Manslaughter and Culpable Homicide in the medical profession

July 27th 2018

1. The Academy of Medical Royal Colleges

The Academy of Medical Royal Colleges (the Academy) is the coordinating body for the UK and Ireland's 24 medical royal colleges and faculties. By bringing together the expertise of the medical royal colleges and faculties it drives improvement in health and patient care through education, training and quality standards. More information can be found at www.aomrc.org.uk. We welcome the opportunity to provide a short submission to the Review.

2. Scope of submission

This submission has not sought to address the specific questions set out by the Review. We apologise for not following these suggestions but did not feel that we were qualified to comment on many of the specific issues raised.

Our submission therefore focusses on the Academy views and activities on

- The use of Gross Negligence Manslaughter (GNM) and Culpable Homicide (CH)
- Expert witnesses
- Local Investigations and organisational learning
- The role of the regulator

3. Gross Negligence Manslaughter/Culpable Homicide

The question of the use of Gross Negligence Manslaughter (although not specifically Culpable Homicide) has been a concern for the Academy for some time and not simply in relation to the recent Bawa-Garba case. In November 2015 the Academy Council, which comprises the Presidents of all our member Colleges and Faculties, considered the issue of GNM and, particularly, the use of expert witnesses at the request of the Royal College of Surgeons of England. This followed a petition received by several Colleges from a group of doctors. The Academy undertook work on the issue of expert witnesses including meeting with the Coroners Service and Ministry of Justice. The Academy again considered the issue in November 2016 following receipt of a further petition specifically about the use of GNM and calling for a review of its provisions.

When the Academy considered the question of the use of GNM in 2015 and, in more specific detail in 2016, on both occasions it made a clear and explicit statement that doctors should

not be especially exempt from criminal prosecution. In discussion the Academy Council stated that doctors and other clinicians cannot and should not be excepted from legislation that applies to the rest of the population. The Academy also recognised that it is possible that there can be individual culpability alongside system failure. That position was endorsed in February this year when specifically considering the Bawa-Garba case.

The question of the threshold for GNM was not considered by Council. However the Council did express concern at what appears to be variation in practice and standards and how the police and CPS access clinical expertise on which to make decisions about prosecutions.

The Academy believes there are questions of access to clinical expert advice, consistency and standards of investigations and the basis and threshold for prosecution which need to be addressed.

Clarity on what constitutes a criminal act in medical practice, supported by clear guidance and examples, should be agreed and used consistently by hospitals, regulators and the legal professions.

4. The role and use of medical experts/expert witnesses

Academy activity

In 2015 the Academy's consideration focussed on the role of medical experts/expert witnesses. The petition to Colleges called on them to

- Review, register and oversee the quality and training of expert medical witnesses to coroners and criminal courts
- Form a Working Party with external organisations to review the quality control of expert witnesses
- Establish a process of nominating expert witnesses
- Suggest that the CPS collects data on the professional occupation and ethnicity of those it chooses to investigate

The Academy consulted its member organisations on these suggestions. Whilst there were common concerns about the variation in the quality of expert witnesses there was a clear agreement that Colleges did not wish to become involved in regulating, vetting or registering expert witnesses. Colleges felt this would be a very considerable task fraught with difficulties.

It was agreed, however, to facilitate a meeting with the Coroner's service, Ministry of Justice and other stakeholders about improving standards of expert witness. A meeting was held in late 2017. There were shared concerns over the standards of expert witnesses in some cases and over a lack of common standards and expectations amongst both witnesses and in the commissioning of witnesses in various settings. There was again no enthusiasm from organisations to establish or run any register of expert witnesses as it was felt that the process would be too complex and difficult

It was agreed that there would be value in producing a short easily comprehensible guidance document endorsed by a range of organisations setting out the expectations on doctors appearing as expert witnesses and as a guide for those commissioning medical experts. The document would be both for individual doctors and for organisations commissioning

witnesses. Unfortunately, after the meeting the Coroners Service felt that they could not continue involvement in process and the work did not progress.

Issues

The concerns of Colleges essentially related to how to assure that an individual expert is appropriately up to speed with current practice and, importantly the context of the clinical practice e.g. a highly specialised clinical academic may be expert on a clinical issue but not recently involved with the reality of clinical practice in a day to day basis. Conversely, in historical cases, the expert may not fully understand established practice at the time of the incident. The Academy would expect that a medical expert holds a current licence to practice.

The problem is also that it is obviously extremely difficult to know where an individual “expert” sits on the spectrum of clinical views and the extent to which that opinion reflects mainstream or established clinical opinion. To that extent there may be a role that Colleges can play in helping provide that assurance.

Consideration could also be given to a requirement for some form of self-declaration by medical experts/expert witnesses as to the scope of practice and areas of expertise.

Consideration should be given to the role that Medical Examiners, when properly established, could potentially play in providing expertise at an early stage of an investigation process.

Williams Review

You will be aware that Sir Norman Williams’ Review called on the Academy to lead work to promote and deliver high standards and training for healthcare professionals providing an expert opinion or appearing as expert witnesses. The Academy Council was pleased to accept the recommendation and will be taking this forward by, firstly, drawing up a framework of standards/good practice and subsequently, developing proposals for training based on the agreed standards/good practice. We will obviously seek to address the issues highlighted above.

5. Local Investigations and organisational and system learning

Whilst there are many diligent and well executed local investigations we feel the overall standards need to be improved across healthcare providers in all countries. We believe that insufficient attention is paid to developing the skills and competence of those carrying out what is a task requiring specific skills and expertise.

Whilst the Academy’s focus is on individual doctors in training, we also believe that is essential that reflective learning, openness and transparency operates on an organisational as well as an individual basis following an incident. Emphasis on system reflection as well as individual reflection will reduce this risk by putting the responsibility on the system owners rather than seeking to identify an individual to blame. We have raised this in discussion with CQC who recognise that organisations and systems need to ensure they reflect on incidents in an open manner.

We support the of tools such as the recent Just Culture Guide produced by NHSI building on the work of the Incident Decision Tree which seeks to help identify and differentiate between individual and system issues.

We hope that the Healthcare Safety Investigations Branch (HSIB) is resourced sufficiently to ensure it can carry out investigations which lead to improved learning and also help develop spread expertise in incident investigation.

6. Regulatory issues

The Academy recognises the challenges that face the GMC in dealing with professionals following a criminal process for gross negligence. The GMC operates within the context of current law and it has responsibilities in terms of maintaining public confidence in the profession as well as protecting patient safety. This may incur a tension with providing a supportive approach for clinicians involved system failures.

Identifying what constitutes a potential loss of public confidence in the profession seems considerably more complex than identifying a potential performance threat to patient safety. The Academy has no simple answer to the question but feels it is an issue worth open and honest debate. The Academy would be pleased to take part in such an exercise

Colleges have not traditionally involved themselves in providing emotional, pastoral and other support for doctors whether facing a patient complaint or who have an allegation or charge of gross negligence manslaughter or culpable homicide and are being investigated by the GMC. There are indications that is beginning to change, and two Colleges have recently set up support mechanisms and others are exploring the issues. Access to such provision is obviously important and has probably been overlooked previously. It is hard to see how this could be a role for the regulator if they may be taking action, but they could certainly signpost to available services.

7. Preventing harm

The thrust of all the points above is on the NHS, legal and regulatory system response to serious incidents and mistakes. Whilst this is the focus of the review it would clearly be preferable if mistakes and harm, including GNM, were prevented in the first place and did not happen.

Elimination of all error in healthcare may not be realistic. However, the Academy believes that much more emphasis needs to be placed a prospective approach which seeks to identify and avert risk. This entails addressing issues of culture, processes and training. The service should devote its efforts to training, supporting and helping staff to avoid errors rather just investigating past mistakes – important though that may be.

The Academy is currently working on developing a syllabus for a proactive, systems approach to providing safe patient care (“Safe Clinical Systems”). This is aimed at promoting a proactive approach to risk rather than a retrospective investigative approach. We are engaging closely with HEE, NHSE, NHSI and CQC and there is considerable enthusiasm for the work. Whilst we are initially focussing on medical staff we see this as essentially a multi-disciplinary issue.

The Academy would be happy to provide further detail of this work in progress.