

RCS evidence: Williams Review into gross negligence manslaughter in healthcare

Overview

The Royal College of Surgeons (RCS) welcomes the opportunity to provide written evidence to Professor Sir Norman Williams' rapid review into the issues pertaining to gross negligence manslaughter (GNM) in healthcare. This expands on the key points given to the Review by our President, Professor Derek Alderson, in the oral evidence session on 5 April.

We shared the concerns of the medical community about the high profile cases of Dr Hadiza Bawa-Garba and Mr David Sellu. These were not only tragic for the families involved but underlined the urgent need for the application of manslaughter by gross negligence to be clarified and reformed. Although the number of cases in relation to GNM remains small, they are often the subject of intense media attention, and the ramifications of these investigations for the patient's family and the healthcare professionals involved can be profound.

It is clear that our health and legal systems must protect patients from avoidable and unnecessary harm. However, they should do this while being clear about the difference between GNM, basic human error in medical practice, and where the health care system in which the doctor is working is to blame. They should also do this while enabling healthcare organisations to complete an open and honest appraisal of what went wrong and how to avoid any mistakes or errors from happening again.

Our written evidence focuses on the first two themes in Sir Norman's Review. We welcomed the General Medical Council's (GMC) decision to launch an independent cross-UK review into the application of GNM and hope this will provide an opportunity to reflect on the lessons that need to be learned in relation to how they deal with professionals following a criminal process for GNM.

Key recommendations

1. There should be **clearer guidance and support for hospitals, coroners, the police and the Crown Prosecution Service** to ensure only appropriate cases of GNM are investigated. To improve consistency, cases should only be progressed following consultation with the Chief Coroner or Director of Public Prosecutions.
2. A **national specialist unit should be established within the police force** that has the expertise and experience to handle GNM cases
3. Healthcare professionals who act as **expert witnesses in criminal cases should be given mandatory training**. The RCS is keen to work with other organisations to produce **guidance setting out the expectations on those appearing as expert witnesses and those commissioning them**. We would also support a **register for expert witnesses in criminal cases** as long as it is fully funded and properly scoped.

4. Attention should be given to **understanding systems failures following an adverse event** so that organisations, rather than individuals, can be held to account when there are significant resource shortfalls.
5. All staff must be encouraged to **reflect honestly, openly and safely, and without the fear of recrimination** as part of the vital learning process. In order to reinforce this, **written reflections with the sole purpose of education and training should be given legally privileged status.**

How we ensure healthcare professionals are adequately informed about GNM and how the processes used in GNM cases could be improved

Improving GNM investigations

The RCS has experience of supporting healthcare organisations with investigations into adverse events through our Invited Review Mechanism (IRM) service that provides expert independent and objective advice when an external expert opinion is requested. Through this work we have experience of a small number of cases that have been subject to an invited review being considered for referral to the police for GNM. Our experience of this work has demonstrated the need for greater consistency around how GNM cases are initiated and investigated. We understand there are far more investigations and prosecutions of healthcare professionals for GNM than there are successful convictions. It would be useful to explore this discrepancy to ensure that GNM charges are only applied in extreme cases.

There are often multiple bodies considering the case for GNM before criminal charges are brought. Moreover these investigations can be lengthy and sometimes run in sequence with GMC inquiries, which only exacerbates the distress for all concerned. We feel that hospitals, coroners, the police and the Crown Prosecution Service (CPS) would benefit from better support and guidance to enhance understanding on when to pursue charges of GNM. This guidance should define the high threshold that has to be met before an unexpected death can be considered criminal and highlight the significant role that systematic failures can play when deaths occur in a medical setting.

For example, there appears to be wide variation over which suspected GNM cases are referred to the police for investigation. With many referrals coming from coroners, clearer guidance for this group in particular would help to ensure only appropriate cases of GNM are investigated. Moreover to improve consistency, we suggest cases should only be referred after consultation with a senior figure such as the Chief Coroner. In a similar vein, guidance would help the CPS to decide whether to prosecute healthcare professionals accused of GNM and liaison with the Director of Public Prosecutions would verify whether this would be in the public interest.

Through our IRM work, we have sometimes encountered difficulties when advising the hospital commissioning the review to refer cases of suspected GNM to the police. Often the police do not have any experience of handling the multiple and complex factors surrounding a death in a healthcare setting. Therefore we recommend that a national specialist unit should be established within the police force that has the expertise and experience to handle GNM cases.

Use of expert witnesses

The RCS strongly welcomed the decision by the Court of Appeal in 2016 to quash the surgeon David Sellu's conviction for GNM. Many in the surgical community were greatly concerned by the case. The Court of Appeal's judgement raised questions about the role of expert witnesses in the

original trial as they made repeated assertions that gross negligence had occurred when that was a matter for the jury to consider. Other cases have also demonstrated that the quality of evidence given by expert witnesses is variable.

Although there are support structures for expert witnesses, such as the Academy of Experts, the Expert Witness Institute and a non-regulated UK Register of Expert Witnesses, there is no common set of standards to which they should adhere. The RCS recommends that healthcare professionals who act as expert witnesses in criminal cases should be given mandatory training. We are also keen to work with other organisations to produce guidance setting out the expectations on those appearing as expert witnesses and those commissioning them. In addition, we would support a register for expert witnesses in criminal cases as long as it is fully funded and properly scoped.

System failures

The RCS is seriously concerned that individual healthcare professionals are sometimes prosecuted for GNM in the face of clear systems failures – perhaps because they are easily identifiable and immediately accountable when things go wrong. Detailed commentary on this can be found in our joint position statement with the Association of Surgeons of Great Britain and Ireland, Royal College of Surgeons of Edinburgh, Royal College of Physicians and Surgeons of Glasgow and Federation of Surgical Specialty Associations on the *Legal Aspects of “Medical Manslaughter”* that was submitted to the Williams Review.

Patient care is almost never delivered by an individual in isolation, but as part of a multidisciplinary team, composed of members with mutually complementary roles and responsibilities, and within corporate structures responsible for the provision of training, supervision, audit and clinical governance. Therefore there should be a distinction between healthcare professionals who make momentary errors under the pressure of a clinical environment, and those who display incompetence through a catalogue of poor decisions. However systems failures are often not considered in GNM cases, even when they may have had an impact on the actions of the healthcare professional that led to the fatality.

We believe that attention should be given to understanding systems failures following an adverse event so that organisations, rather than individuals, can be held to account when there are significant resource shortfalls. This would also provide an opportunity to learn from mistakes and address patient safety issues. We understand this already happens in Scotland so it would be useful to explore the reasons for the lack of corporate manslaughter prosecutions against healthcare organisations in England and Wales.

How we ensure the vital role of reflective learning, openness and transparency is protected

The RCS has promoted the value of reflective learning, openness and transparency through our *Good Surgical Practice* and *Duty of Candour* guidance. We are committed to encouraging a culture of openness and honesty in order to facilitate learning and improvement. It is of serious concern that the recent spotlight on GNM may result in healthcare professionals being less open about mistakes for fear of litigation.

Following the High Court ruling to erase Dr Bawa-Garba from the medical register and the concerns raised by trainees about reflective practice, we supported the statement released by the Academy of Medical Royal Colleges (AoMRC) that emphasised the following points:

- Doctors in training must be given adequate high-quality clinical supervision, even in the most stressful and pressured environments. They must be confident that they are able to make decisions with sufficient oversight from consultants in a way that protects them and their patients while allowing them to work and develop.
- All staff must be encouraged to reflect honestly, openly and safely, and without the fear of recrimination as part of the vital learning process. The threat of this being used in a potentially negative way may potentially promote a lack of candour as well as loss of learning opportunities.
- There should be an understanding that safe and effective care is delivered through systems – and each part of these systems must function. This, by definition includes the need to ensure safe staffing levels, functioning IT, supporting those returning to work and must be scrutinised as a whole and improved in the light of near misses, safety incidents or patients being harmed.

Through the Joint Committee on Surgical Training (JCST), we have been actively promoting the AoMRC's *Summary guidance: Entering information into an e-portfolio* that sets out the principles of reflective practice for doctors in training. We also support the GMC's decision to revise its reflective practice guidance in conjunction with the AoMRC, British Medical Association (BMA) and the Conference of Post-Graduate Medical Deans (COPMeD) and look forward to its publication in the summer.

In addition, the RCS supports the call from the GMC, BMA and the Medical Protection Society (MPS) for written reflections with the sole purpose of education and training to be given legally privileged status. This should include reflections in all education and training documents, such as e-portfolios, annual appraisals, training forms and the annual review of competence progression, whether completed by a doctor or a consultant/supervisor. However if such legislation were to be introduced, we believe there should be clarity about the level of protection it affords and when transparency might be in the public interest.

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