Royal College of Physicians

Response to Dame Clare Marx's review of gross negligence manslaughter and culpable homicide

1. The RCP welcomes this consultation and the GMC's desire to identify opportunities for improvement in procedures and processes which will support just decision making and the application of the law. As a profession and society we must focus on developing a just culture[1] as opposed to a blame culture. The latter is a barrier to improving quality and safety in healthcare, whereas the former actively fosters improvement by encouraging openness and learning.

2. Several RCP members with particular expertise and experience in this area are making comprehensive responses to the review. The RCP responded to the recent rapid policy review into gross negligence manslaughter by Professor Sir Norman Williams. And the RCP looks forward to speaking directly to the review team. We therefore make five main points in this submission:

    a. doctors should not be prosecuted for deaths that result from errors: involuntary mistakes, slips and lapses
    b. the focus should be on learning from errors to improve patient safety, rather than apportioning blame
    c. the context in which a patient died is of paramount importance, particularly the system and environment in which a healthcare professional was working
    d. a human factors assessment approach should be taken in investigations
    e. there needs to be greater standardisation in terms of expert witness training and selection, investigation, and decision to prosecute.

3. In addition, the RCP welcomes the fact the GMC is investigating the high level of complaints against black and minority ethnic doctors compared with white doctors. The fact that none of the healthcare professionals convicted of gross negligence

[1] A just culture is one "in which front-line operators or other persons are not punished for actions, omissions or decisions taken by them that are commensurate with their experience and training, but in which gross negligence, wilful violations and destructive acts are not tolerated." Article 12, paragraph 2, Regulation (EU) No 376/2014 of the European Parliament and of the Council

manslaughter in the past 10 years have been white, when around 60 per cent of the NHS medical staff is white, suggests a significant level of bias.

4. The RCP considers that a patient death only becomes a criminal act of manslaughter or culpable homicide when someone is wilfully negligent or acts with deliberate intent to harm. By wilful negligence we mean

    a. acting with disregard of or indifference to someone's safety
    b. not following agreed protocols or accepted practice knowingly and for no valid reason
    c. undertaking something for which one has not been trained.

5. Lessons will only be learned from investigations following serious clinical incidents when the focus shifts from apportioning blame. Focusing on culpability does not serve patients; their families, friends or carers; the general public; doctors; nor the NHS.

6. Everyone concerned must have confidence that the primary aim of local investigation is to identify what went wrong and why. If the primary aim is to apportion blame it provides a perverse incentive to obfuscate, which makes it is less likely that systemic faults will be uncovered and future lives saved. Criminalising error reduces patient safety, and militates against families, friends and carers receiving the support, clear explanations and apologies they need and deserve.

7. Everyone concerned must also have confidence that the local investigation is competent. Currently, local investigations are conducted locally, which means there is a significant risk of bias or obfuscation. There must be independent criteria for establishing the competence and skill of those conducting investigations. The criteria might include a requirement that the investigation be conducted by people not employed by the hospital or trust.

8. Context is all important when deciding if someone was wilfully negligent or acted with deliberate intent to harm. An action or omission cannot be judged to be truly, exceptionally bad outside of context. The actions of a trainee doctor in a small local hospital, with a high burden of competing tasks, some of which are unfamiliar, and when suffering from fatigue, must be treated differently to the actions of a consultant in a large teaching hospital.

9. Rota gaps, whether or not doctors have breaks and access to rest facilities, quality of induction and a host of other factors must be taken into account. Organisations must make sure the environment in which their staff are working reduces the chance of error. That includes functional and effective IT systems, access to rest areas and refreshments, and having the time to take breaks.

10. Investigations should focus on identifying the human (environmental, organisational, technological, job and individual) factors which led to a death. Only by understanding the things that influence people and their behaviour will we reduce harm.

11. Any police investigation should be undertaken by a specialist force as recommended by the Williams review. Investigations must encompass systemic factors, which may be indicated by changes that take place in a hospital after an event.

12. For expert witnesses to be independent, they must meet a set of agreed criteria and be appointed by an agreed process. They should receive training in certain areas, such as unconscious bias and human factors. Their evidence must be collected as early as possible to inform the decision to prosecute or not. They must be experienced in relevant clinical practice, and GMC registered with a license to practice.

13. Finally, more attention needs to be paid to supporting doctors who make errors, whether or not they become subject to criminal investigation. The results of our most recent census highlight the rising pressure understaffing is having on doctors in all four nations and the dangerously long hours some are having to work. Issues with junior doctors are also evidenced, with trainees reporting a colleague calling in sick for up to half of all on-call shifts. Through no fault of their own they are working in an environment that is conducive to error, and error can have a significant impact on the mental and physical health of a doctor. For that impact to be compounded by being held individually accountable for the failings of the system, when you were acting in good faith, is inexcusable.