DATE: 9 August 2018

RESPONSE OF: The Royal College of Psychiatrists in Scotland

RESPONSE TO: Written submissions to inform Dame Clare Marx's review of gross negligence manslaughter and culpable homicide

This response was prepared by the Royal College of Psychiatrists in Scotland. For further information please contact: Patrick Garratt on 0131 344 4966 or at patrick.garratt@rcpsych.ac.uk.

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

RCPsych in Scotland

Workshop to develop response to the GMC commissioned review of gross negligence manslaughter and culpable homicide (the Dame Clare Marx Review)

1. **About you**

Royal College of Psychiatrists in Scotland

2. **Please tell us your name**

Royal College of Psychiatrists in Scotland

3. **The country you live in**

Scotland

4. **Your job title/role (or leave blank if not applicable)**

5. **The name of your organisation or employer and location (again, if applicable)**

Royal College of Psychiatrists in Scotland, Scotland

6. **Your email address if you are happy for us to contact you about your submission**

scotland@rcpsych.ac.uk

7. **Please select the group below that you feel applies most to you or the organisation you are responding on behalf of:**

Professional representative organisation, college or trade union

8. **If you are a medical professional, please select the options below that apply to you:**

N/A

This section focuses on what you consider to be 'criminal acts' by doctors

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

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

In Scots law, murder is committed when the accused has acted with the *intention* of killing the victim, or where the accused's conduct has been 'wickedly reckless', whereby the loss of life was predictable to such a degree that the death was likely to have happened. Culpable homicide requires there to have been a death where the accused has caused a loss of life through unlawful conduct, but where there was no intention to kill and the actions do not meet the criteria to warrant a murder prosecution.[1] As part of the criteria for culpable homicide, an act must be that of an intentional, reckless or grossly careless nature.

This section focuses on the experience of patients and their families

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 processes for local investigations, and the variation of these investigations, are currently being reviewed by Professor Craig White. The Scottish Government has commissioned a consultation entitled 'Learning from Loss: tell us about your experience of the investigation of the death of a person being treated for mental illness, personality disorder, or learning disability: Family and carers survey'. The remit of the 'Learning from Loss' consultation is specifically about mental health services. We would therefore advise the Clare Marx Review to liaise with Professor Craig White, and profit from the findings of the Scottish Government's review into the experience of families and carers in cases where patients have died within the care of mental health services.

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?**

13. **What is the system for giving patient's families space for conversation and understanding following a fatal clinical incident?**

[1] Scottish Government, 'Information for Bereaved Families and Friends Following Murder or Culpable Homicide, 2004

Should there be a role for mediation following a serious clinical incident?

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

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

<u>This section focuses on processes leading up to a criminal investigation</u>

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?**

Like the previous section, this question is best answered following the findings of Professor Craig White's review.

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, organisation 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 s systematic process for identifying 'root causes' of problems or events and an approach for responding to them.**

Effective root cause analysis can systematically highlight constituent parts of systems which lead to failings. However, if root cause analysis is carried out too mechanically, the broader parameters and system pressures which doctors and other agencies are working under will not be acknowledged.

Human factors assessment takes the position that humans are flawed, explores factors highlighting why errors were not picked up, and assesses the wider healthcare system.

RCPsych in Scotland thinks in the context of a healthcare system which is multidisciplinary, consists of multiagency personnel, and relates to system-based issues, it would be effective to take a human factors approach to local investigations.

18. **Typically, who is involved in conducting investigations following a serous clinical incident in hospital/trust/board or other healthcare settings and what training to they receive?**

RCPsych in Scotland would like to direct the Clare Marx Review team to Professor White's Review and the survey for staff members.

Presently, there are undesirably broad variations between Health Boards across Scotland. However, there are examples of good practice, such as NHS Grampian which has instigated training in 'significant adverse event reviews'.

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

The White Review is aiming to establish the extent to which the actions of internal and external investigations are commensurate with a set of policies and principles which would ensure good practice. Adverse event reviews should not be driven solely by complaints.

As suggested in the survey to staff as part of the White Review, healthcare providers should have policies on their own investigations which:

- outline the structure of adverse incident reviews'
- emphasise openness and transparency;
- commission and organise reviews;
- share and communicate information with family and carers;
- establish mechanisms for scrutiny and quality assurance; and
- and ensure family members are aware of the outcomes of local investigations.

Similarly, the White Review survey also highlights the following principles to underpin good practice in both internal and external investigations:

- clarity of purpose and method;
- sensitivity to the needs of families, carers, victims and other service users;
- appropriate membership;
- timely and proportionate;
- openness to external scrutiny;
- appropriate safeguards and support for staff members;
- clarity in the presentation of findings;
- appropriate links with other agencies and sources of information;
- system of accountability;
- system of evaluation;
- potential for feedback from participants; and
- transparency in process of implementing recommendations.

Sufficient resources need to be provided to carry out these reviews. If there is not enough time to carry out investigations, then outcome will be of poor quality.

RCPsych in Scotland would also like to highlight a recently established national framework for adverse event reporting and reviews from Healthcare Improvement Scotland (HIS), the statutory body responsible for issuing guidance on adverse events.[2] Within the HIS report 'Learning from Adverse Events through Reporting and Review', seven overarching principles are highlighted:

- Emphasis on learning and promoting good practice across Scotland
- System approach
- Openness about failures
- Just culture
- Positive safety culture
- Personal, professional and organisational accountability
- Teamwork

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.**

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

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

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?**

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

[2] Healthcare Improvement Scotland, 'Learning from adverse events through reporting and review - A national framework for Scotland', 2018, p.8

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)**

The focus of any review needs to be clear and explicit. Adverse event reviews are not about maximisation of perfection, but rather, at looking what can be learnt. Adverse event reviews should be separate from disciplinary processes, as the purposes of these two investigations are different. If a review highlights failings relating to disciplinary reviews, then disciplinary procedures should follow through with these issues – disciplinary outcomes should not be the responsibility of a review.

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?**

There is presently insufficient support for doctors following a serious clinical incident. However, this is not just about doctors. A 'whole systems' approach must be adopted when addressing the healthcare system. We should not be looking for one individual to blame, and similarly, we should not look to provide support to only type of person. Training should be systemic across agencies and staff types across the NHS, and should be neutral.

The Clare Marx Review is specifically focused on doctors, but if a human factors approach is to be adopted, the breadth of such a review must encompass other agencies. For example, the Review should consider how administrative staff are supported.

RCPsych in Scotland would also like to highlight that NHS Scotland does not provide a specific health service for doctors' mental health, whereas England and Wales have such specific health services.

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?**

In Scotland, the decision to prosecute a healthcare professional for culpable homicide is considered first by the Procurator Fiscal (PF), and then authorised by the Lord Advocate in Scotland.

There is also a system for death certification in Scotland which includes the Procurator Fiscal. The Scottish Fatalities Investigation Unit (SFIU) is a specialist unit of the Crown Office and Procurator Fiscal Service (COPFS).

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?**

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, ethnic) doctors? If so, which groups are affected by this and how can those barriers be removed?**

There must no direct or indirect discrimination for any doctor with protected characteristics. Moreover, doctors who were not educated in the UK must be inducted on the regulation and principles of review and reporting systems.

<u>This section focuses on inquiries by a coroner or procurator fiscal</u>

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?**

In cases with the Procurator Fiscal (PF), they will make enquiries and develop proportionate responses to the circumstance. This may initially involve post mortem investigation. Following post mortem investigation, it may involve the consideration of an adverse event review. The PF will then adjudicate on whether next steps must be made. Sometimes, the PF will be satisfied that an appropriate agency is undertaking the review, such. In other cases, they will refer to a Fatal Accident Inquiry (FAI). The most common variety of FAIs in mental health are in the context of prison suicides. However, by the time they are audited, they are often reported many years after the initial incident.

Public interest as an important principle underpinning the decision to pursue charges of culpable homicide against healthcare professionals. There have been no convictions of a healthcare professional for culpable homicide. Only one healthcare professional was charged with culpable homicide, but was later acquitted at the Scottish High Court. A subsequent Medical Practitioners Tribunal decided against the GMC's request of sanction of erasure, and chose to impose a suspension period of 12 months.[3]

It is also important to highlight the purpose of carrying out local investigations whereby lessons are learnt from the Mental Welfare Commission published a report in 2016 into the investigation into the care of Ms OP, a mother who

[3] (BMJ 2017; 359: j52452)

suffocated their child whilst experiencing postnatal depression.[4] One of the recommendations which followed the publication of the report was for the Scottish Government to establishing a national Managed Clinical Network (MNC) specifically for perinatal mental health. There was no subsequent need for a Fatal Accident Enquiry. Lessons were learnt from a case of adverse outcome. This case illustrates accountability can be apportioned, and systems amended, without individual prosecution.

Healthcare and regulatory agencies should work aspire to develop internal review and reporting process through where points can be identified quickly, as external processes are more likely to be drawn out. Agencies should be encouraging immediate debriefs, quick reviews, and for proportionality, scrutiny from external bodies may be profitable. RCPsych in Scotland endorses different levels of scrutiny provided there is clarity on each review. From the outset, the purposes and outcomes of any investigation should be highlighted – that is, specifying whether the purpose is about learning or about apportioning responsibility.

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?**

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

Independent medical expert evidence is key to the decision-making process of the Procurator Fiscal system, and in the decision on whether an FAI should be carried out, and to what extent a review would serve the public interest.

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?**

We do not presently have a robust selection process. There is a wider concern about the provision of medico-legal reports for the Crown. The process is presently driven by word-of-mouth and recommendations.

There are resource issues in the selection process. The Procurator Fiscal must pay consultants to carry out the selection process on behalf of the Crown. However, as the Scottish Courts pays less than Health Boards pay Consultant Psychiatrists for their pro-rata work, there is less of an incentive for healthcare professionals in some instances to provide evidence in an inquest or FAI.

[4] Mental Welfare Commission, 'Ms OP: Investigation into the care and treatment of Ms OP by NHS Board C',

34. **Do the same standards and processes apply regardless of whether they are providing their opinion for a local investigation, an inquest or a fatal accident inquiry process? If not, why not? For example, is there a higher level or different type of expertise or skill set required?**

Professional standards should be uniform, but the terms of reference should be different, and vary proportionately to circumstance.

In terms of principles, healthcare professionals should possess both fundamental knowledge of their area, and have sufficient and recent clinical experience. They *must* have a knowledge of current medical practice.

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

There are presently no systems of quality assurance. We would look to any guidance which the GMC may produce on quality assurance processes for expert evidence.

It is important to consider the relatively few number of FAIs. Moreover, if there is an increase in the number of FAIs – and hence an increase in the amount of time spent on review processes that may alternatively be spent by doctors in clinical practice - there is a trade off in terms of the delivery of healthcare. Criminal behaviour must be addressed, but the principle of proportionality must be adhered to.

<u>This section focuses on police investigations and decisions to prosecute</u>

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?**

Evidence gathered by a hospital or Health Board would most likely form part of the final sets of evidences considered, though we are not aware of any criminal investigations to date which have involved this.

37. **What is the charging standard applied by the prosecuting authorities in the cases of GNM/CH against medication practitioners? How does the charging standard weigh the competing public interest in improving patient safety?**

For a healthcare practitioner to be prosecuted for culpable homicide, the mens rea of the offence in question must be proved to be characterised by criminal intent. There must such a degree of recklessness which could only be characterised as displaying a gross indifference to the safety of the public. Therefore, the charging standard in Scotland is one which demands a case to be proven as reckless, either in the in the sense of intentionality or gross carelessness. These parameters for asserting culpability are better suited when determining the culpability of a doctor in the death of a patient than the charging standards for gross negligence manslaughter in England and Wales.

RCPsych in Scotland recommends the Scots law approach to culpable homicide as an example of best practice for charging standards. Public interest is vital in the respect of how it acts as a legal test in an individual case. As a recent article written by Dr Rob Hendry, Medical Director at the Medical Protection Society has highlighted, by ensuring the PF considers whether a prosecution of a healthcare professional is in the public interest:

'In arriving at a decision they have to balance the interest of justice with supporting a patient safety culture…The MPS is proposing that the director of public prosecution authorises all GNM prosecutions involving healthcare professionals. This, as in Scotland, would ensure that the vital question of whether public interest is served by a prosecution is considered.'[5]

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?**

In Scotland, the PF looks at whether there is a public interest.

It is common for the PF to gather evidence from experts. It is important that in the instruction of experts, they are advised to consider wider system pressures. Decision makes must understand that healthcare is an organisational and multifaceted system, and should understand the human factors analysis of healthcare.

39. **Do they 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**

[5] Rob Hendry, 'Gross negligence manslaughter does not exist in Scotland — is it time to move English law towards the Scottish position?', *British Medical Journal Opinion,* 2018: https://blogs.bmj.com/bmj/2018/03/13/rob-hendry-gross-negligence-manslaughter-does-not-exist-in-scotland-is-it-time-to-move-english-law-towards-the-scottish-position/

there are need for detailed prosecutorial guidance for this offence (similar to that for assisted suicide)?

We would recommend the Clare Marx Review contact the Crown Office to gather more information on this point.

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

It is difficulty to comment on this in the Scottish context, due to the lack of criminal prosecution for culpable homicide amongst healthcare professionals in Scotland. However, there is an understanding that family members feel left out and disempowered following tragic fatalities. Therefore, a balance may be found in providing information to family members and ensuring lessons are learnt, without resorting to prosecutions. The legal culture within Scotland is as such that the decision to embark upon a criminal prosecution is less likely than England and Wales, as it is the Crown Office which ultimately decides on the credibility of a decision to prosecute.

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?**

A regulatory system is the best system to use to ensure patient safety is prioritised and lessons are learnt from adverse events. The decision to pursue a criminal prosecution would be underpinned by whether the legal tests are satisfied, and whether prosecution is in the public interest. There may also be other mechanisms to learn lessons from and to serve the public interest, such as a Mental Welfare Commission (MWC) inquiry, or an FAI.

Key regulatory systems include Healthcare Improvement Scotland (HIS) for suicide, and the MWC which provides statutory oversight of mental health services. These bodies provide regulatory oversight, and commission and share guidance to improve clinical practice, rather than to decide upon criminal prosecution.

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

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?**

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?**

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

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?**

As referred to in previous questions, the approach to culpable homicide in Scots law is one which embeds principle and proportionality.

<u>This section focuses on the professional regulatory process</u>

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?**

Fitness to practice reviews should be held in Scotland for Scottish–domiciled doctors, and follow Scottish rules of evidence.

A distinction must be made between criminal prosecution occurring through gross carelessness in a doctor's clinical practice, and criminal acts occurring outside of a doctor's clinical practice which have implications for their professional practice.

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 bene mistakes that are 'truly, exceptionally bad' or behaviour/rule violations resulting in serious harm or death?**

There needs to be caution in drawing conclusions on the maintenance of public confidence and definitions of professional conduct, particularly when it is difficult to apply legal definitions to specifically medico-legal contexts. 'Truly, exceptionally bad' is underpinned by English law, for which there is no equivalent in Scots law.

The GMC as a regulator and impartial review body may be open to criticism from the public where a criminal prosecution does not occur, though wider criticism does not mean its decisions are inappropriate.

The interpretation of public confidence must be relative to the facts of the individual case and without any presumptions. The overall circumstances of a case must be considered, and medical tribunals should have the right to all evidence available. The context of wider system pressures must be assessed.

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?**

Reflective practice is essential for learning, and making mistakes is an inevitable outcome of medical practice. Structures must be established which support practitioners and ensure they feel safe in discussing their mistakes. If reflections are used as evidence in court against a practitioner, then practitioners are less likely to engage in reflective practice.

A reflection should not be an account of an event. Greater education should be provided to doctors on the purpose of reflective practice, and medical practitioners should be made explicitly aware of what use may come out of reflective practice. These reflections should not be used by regulatory standard.

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?**

Systemic support on a team basis should be made available, however, as previously highlighted, there are limited cases in Scotland where this has been required.

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

Locally focused lessons and outcomes must be shared, and recommendations followed through. The GMC should inspect how the regulatory network of other medical bodies in Scotland learn from quality assurance processes, such as HIS and the MWC. E.g. MWC learns proportionately from examples of both good and bad practice.

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

The structures of the GMC have changed dramatically over the past ten years, and the scope of its work and remit has broadened, including postgraduate medical education and revalidation. We would like to see greater balance in the GMC to consist of more members from the medical profession, and consideration of the return to elected representation. The GMC must recognise that there is a need to restore its authority with medical professionals. There needs to be a reengagement with the medical profession. There is also more work to do within the structures of the GMC to respond to the challenges of devolution with consideration of devolved councils being established in Wales, Northern Ireland and Scotland.