THE ASSOCIATION OF ANAESTHETISTS
of Great Britain & Ireland

13 April 2018

AAGBI response to Professor Sir Norman Williams's Review into Gross Negligence Manslaughter in Healthcare

Role of the AAGBI
The AAGBI represents the medical and political views of over 11,000 anaesthetists in the United Kingdom and the Republic of Ireland. The AAGBI has a broad constitution including education, safety and research in anaesthesia, as well as the professional aspects of the specialty and the welfare of individual anaesthetists.

As the national membership organisation representing the single-largest specialty in the UK (over 11,000 UK members), the AAGBI is well placed to contribute to Sir Norman's review. Specifically, the Association has much experience of assisting, caring for, and supporting colleagues who may be the subject of investigations into their care by the police, CPS, Coroners, GMC, HSIB, Trusts, or Royal Colleges. The AAGBI remains keen to meet with and provide evidence to the Review and regret that our offer to do so has not yet been taken up.

The Association is able to offer a different perspective to that of the Royal Colleges, who as a result of their Charters, are unable to offer such individual support. The AAGBI provides wellbeing support to its members by multiple routes. We feel the Review missed an opportunity to broaden its knowledge of the many issues raised by gross negligence manslaughter (GNM) allegations as we would have been able to describe in detail the work we undertake. Similarly, our long (more than 50 years) history of leading on patient safety has given us a unique perspective on the drivers and inhibitors to changes in this area.

Introduction
The increase in the last decade in the number of healthcare workers being prosecuted for GNM is of concern for three reasons:

- The negative effect on promoting an open and just culture for reporting mistakes, so that errors are investigated to learn lessons and, hopefully, prevent future such mistakes. [Refs 1, 2]. This is fundamental to improving patient safety, as promoted by Don Berwick
- The effect on the morale of an already demoralised and pressurised healthcare workforce. This has led to an atmosphere of vulnerability, along with increasingly defensive clinical practice.
- The impact on reflective practice, which has otherwise proven beneficial not just for trainees, but to all practitioners in their quest to improve their care.

Patient Safety
Medical error is recognised as being the third commonest cause of death after heart disease and cancer. We all make mistakes and human error cannot be eliminated, but we can put in place system changes that reduce mistakes and, importantly, reduce the harm resulting from mistakes that do occur. This has promoted increased interest in the subject of human factors. Fundamental to improved patient safety is the development of a 'no blame' culture that recognises error and encourages healthcare staff to be open and to report readily errors so that incidents can be thoroughly investigated, analysed and learnt from.

Medical error is often complex with no single cause, but a catalogue of human and system errors that combine to produce an adverse outcome. What initially appears to be a simple error is often found subsequently to be part of a far more complex combination of factors that

did not cause, but contributed to, the adverse event. 'Fixing' one of these factors does not prevent an identical adverse event from happening again. A much more systematic approach is needed for improvement.

Criminalising medical error through pursuit of a prosecution for GNM will discourage clinicians from being open about errors and risks, preventing the effective detection of mistakes and learning lessons for patient safety

GNM Prosecutions
We do not seek a change in the law such that there should be no more prosecutions for GNM, but that the law should be applied more consistently and reserved for when there is strong evidence of either unwarranted extreme negligence or reckless or malicious actions. The decisions and process for prosecution of GNM should be the same regardless of where in England and Wales they occur.

Suggestions for achieving this include:

- Process of referral for further investigation – if derived from the local Coroner there should be an overview and a decision made by the Chief Coroner.
- Guidance is issued to investigating teams to weigh the balance between individual and corporate responsibility. We believe many errors, when considered in context, are surrounded by (or predicated on) systematic failure.
- Investigation of potential cases – due regard should be taken of an independent investigation, e.g. by CQC or HSIB.
- Criminal investigation, if required, should be by a specialised, centralised, police unit with experience and expertise in medical error investigation.
- The decision to prosecute should be more consistent by referral to the Director of Public Prosecutions for the final decision.
- The complexity of potential GNM necessarily relies heavily on expert witnesses. These should be carefully selected as being current in clinical practice with contemporary experience in the areas in which they are giving an opinion.
- The Court should take into account the full context in which the clinician was practicing when the mistake was made.

Observations about the recent Bawa Garba case

- The errors made by Dr Bawa Garba were of the type that many of us who work in the current pressurised NHS recognise as ones that we could easily make.
- The Court didn't appear to take into account the large number of improvements introduced by the hospital subsequent to the death of Jack Adcock that indicated the systematic problems that existed when Dr Bawa Garba made her grossly negligent errors.
- The many improvements introduced by the hospital following Jack's death illustrate the learning opportunities from openly investigating such errors.

Supporting Colleagues

In our experience it is essential there is adequate support for clinicians who make an error throughout the duration of any investigation or prosecution process. Too often, those who are suspected or accused of making a mistake are ostracised, or prevented from speaking to others, at a time of greatest need for peer support.

There is a particular risk from repeated, differing investigations. The pernicious effects of double-jeopardy and the duration of sequential processes, lead in many to marked psychological distress and financial difficulties.

Additional Points
An employing Trust/Board/provider (or the one where the incident took place) should be obliged to provide background to the case, listing all those issues already known to the Trust.

There should be a clearer role for the HSIB in the hierarchy of investigations. Their conclusions could be used to inform the criminal process, and place errors into context.

The Review asks about the lessons to be learnt by regulators in how they deal with professionals after prosecutions for GNM. We believe that regulators exist to maintain the standards of the profession and to protect patients. Any sanctions should be appropriate to maintaining patient safety and should not be punitive. Registration should be removed or suspended when the professional is a risk or potential risk to patients or needs remedial measures taken before they are safe. A conviction for GNM does not necessarily mean patients are at risk, and erasure or suspension should not necessarily follow a GNM conviction.

References

1 Paterick ZR, Paterick BB, Waterhouse BE, Paterick TE. The challenges to transparency in reporting medical errors. *J Patient Safety 2009* [https://www.ncbi.nlm.nih.gov/pubmed/22130212]

2. NPSA, Medical Error [http://www.nrls.npsa.nhs.uk/resources/?EntryId45=61579]

Kind regards

Dr Mike Nathanson
AAGBI Honorary Secretary