When Things Go Wrong

(Part 2)

29 October 2021

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When Things Go Wrong

- NHS Complaints / Private Complaints
- PF notification
- Criminal proceedings
- FAI
- Public Inquiry
- GMC

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NHS Complaints

- Within 6 months of knowledge
- Can be 12 months
- Can cover more than one Health Provider – one takes the lead

But not

- Where legal proceedings considered likely
- Where previous investigation & response

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NHS Complaints

- Stage 1

Early Resolution 5-10 days

or escalate to

- Stage 2

Investigation 20 days (plus)

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NHS Complaints

- Stage 2

Investigation 20 days (plus)

- Letter

or

- Meeting

Record of Meeting to be sent

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NHS Complaints

- <u>Relationship with SAER</u>

- For Complaint manager to decide
- NHS Complaint can continue in parallel

  or

- SAER to take account of Complaint

  but vice versa?

- SAER does not replace Complaints investigation

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NHS Complaints

Advantages –

Clear and early explanation while memories fresh

Early opportunity for health professionals to reflect

Prevention of recurrence

Early opportunity to assess / sift

Why as well as what - understanding

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NHS Complaints→ SPSO

(Final Stage)

Only where exhausted NHS Complaint Procedure

12 month time limit

Not if in Court

Independent input

Can result in

Apology

But not damages!

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Private Complaints

- Can vary across Private Health Providers – voluntary
- ISCAS Code of Practice (Independent Healthcare Sector Complaints Adjudication Service)
- 6 month time limit
- Clinical Negligence not covered

"if you believe the healthcare professional has breached professional standards you should contact the professional regulator. If you are seeking compensation, it may be appropriate to seek legal advice"

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Private Complaints

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PF Notification

Reportable deaths – "must"

- Unnatural cause of death

- Natural cause
- Where cause of death can't be identified
- May be related to a suggestion of neglect
- Deaths under medical care

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PF Notification

CROWN OFFICE & PROCURATOR FISCAL SERVICE

SCOTLAND'S PROSECUTION SERVICE

- Deaths under medical care

- Concern by relatives re treatment / contribution to death
- Circumstances might indicate fault / neglect
- Failure of piece of equipment
- Likelihood of SAER

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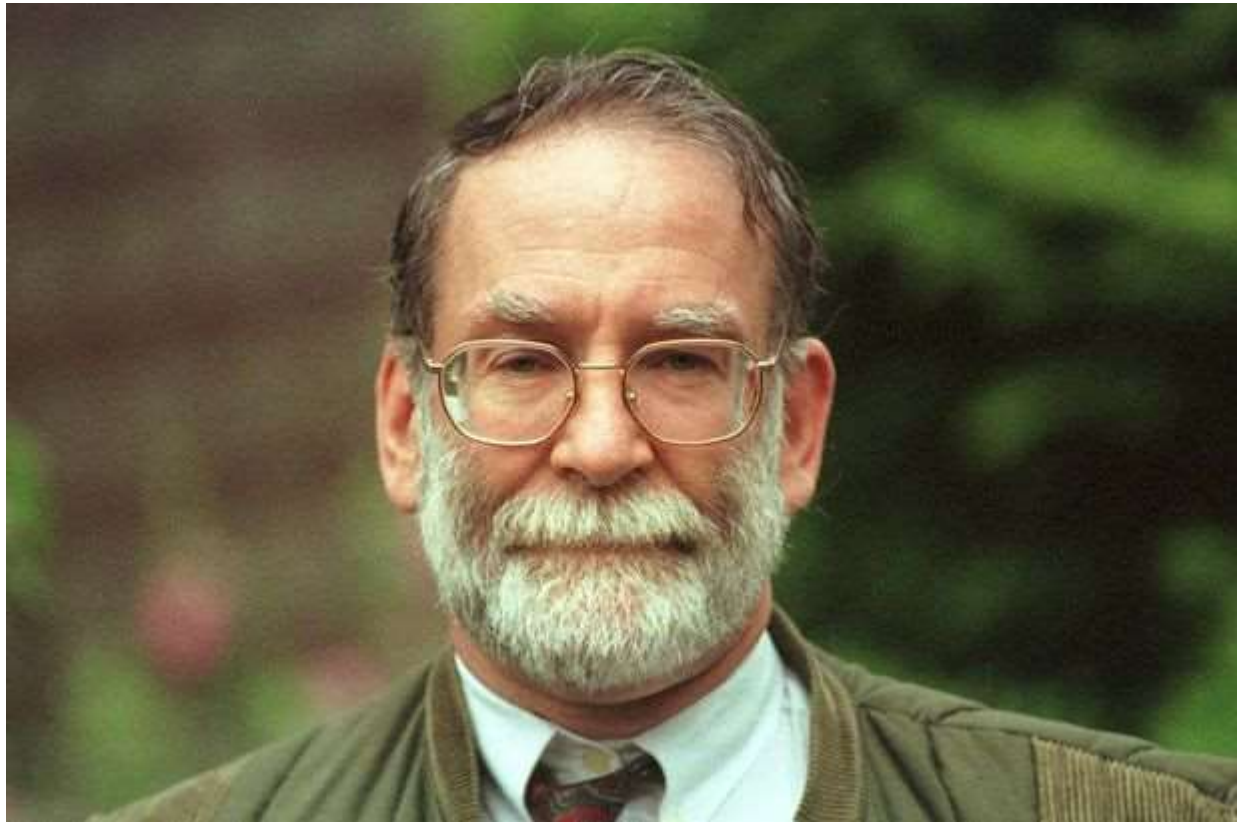
Criminal proceedings



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Criminal proceedings

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Mr David Sellu, Consultant Colorectal Surgeon

- Convicted of manslaughter
- Serious systems failings at Hospital discovered later- “A scalpel in the back”
- Leave to appeal granted in 2015

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Criminal proceedings

Dr Bawa-Garba

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Criminal proceedings

Dr Bawa-Garba

Gross negligence manslaughter

Death of 6 year old child from sepsis

Covering 6 Wards over 4 floors

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Criminal proceedings

<u>Scotland vs England</u>

Gross Negligence Manslaughter

vs

Culpable Homicide

OR

Prosecuting to win

vs

Prosecuting in the public interest?

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Criminal proceedings

Scotland

Health & Safety at Work etc Act 1974, s.3

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Criminal proceedings

Health & Safety at Work etc Act 1974, s.3

- *duty of every employer to conduct his undertaking in such a way as to ensure, so far as is reasonably practicable, that persons not in his employment who may be affected thereby are not thereby exposed to risks to their health or safety*

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Criminal proceedings

Nicola Black 2014

&

Gary Niven 2015

Health & Safety at Work etc Act 1974, s.3

- *duty of every employer to conduct his undertaking in such a way as to ensure, so far as is reasonably practicable, that persons not in his employment who may be affected thereby are not thereby exposed to risks to their health or safety*

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Criminal proceedings

<u>So where are we?</u>

Increasing tendency to criminalise H & S at Work?

Or

Retreat from high water of Dr Bawa-Garba?

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FAI Legislation

- Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976

- Inquiries into Fatal Accidents and Sudden Deaths etc (Scotland) Act 2016

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Fatal Accident Inquiries

- Thursday 21st October 1971

Clarkston Gas Explosion: 22 Fatalities

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Fatal Accident Inquiries

- Thursday 21st October 1971

Clarkston Gas Explosion

- Saturday 23rd October 1971

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Fatal Accident Inquiries

- Thursday 21st October 1971

Clarkston Gas Explosion

- January 1972
- Paisley Town Hall FAI Commencement

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Fatal Accident Inquiries

2016 Act

- Preliminary Hearing - Form 3.7 – Note of issues in dispute
- Intimation of Productions / likely witnesses
- Increased case management
- Fewer surprises!

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Fatal Accident Inquiries

2016 Act

Recommendations –now more future focussed

Post –Determination responses

Follow up

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Fatal Accident Inquiries

2016 Act

Causation

Whereby the death **might realistically** have been avoided….

Harrison (Sheriff Principal Murray) 20th Jan 2021

"….it is not possible to say on a balance of probabilities that any precautions might realistically have resulted in the death being avoided…."

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Fatal Accident Inquiries

2016 Act

Causation

"….it is not possible to say on a balance of probabilities that any precautions might realistically have resulted in the death being avoided…."

An alternative formulation

1. Was there a chance?

2. How sure are you?

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Fatal Accident Inquiries

Relationship with NHS Internal Investigations?

- Overriding principle – in public interest

Relationship with GMC?

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GMC

General Medical Council

Regulating doctors
Ensuring good medical practice

- Role

- Protect patients
- Improve medical education
- Improve medical practice

- Decide who qualified to practice
- Set standards for doctors to follow
- Prevent doctor from putting safety of patients / public confidence in doctors at risk

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GMC

General Medical Council

Regulating doctors
Ensuring good medical practice

- Usually 5 year limit but can be later!!

<u>Triggered by</u>

- “concern” by patient
- “concern” by employer
- self – reporting

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GMC

General Medical Council

Regulating doctors
Ensuring good medical practice

- <u>self – reporting</u>

without delay
if anywhere in the world

- *…found guilty of criminal offence*
- *…charged with a criminal offence*
- *….criticism by an official inquiry*
- *…..judicial criticism that could call your fitness to practice into question*

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GMC

General Medical Council

Regulating doctors
Ensuring good medical practice

- Medical Practitioner's Tribunal

- Parties
- Representative for the GMC
- Doctor / representative – no patient representation

- Balance of probabilities

- Interim orders – eg suspension
- Final orders – warning / suspension / undertakings / erasure

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GMC

General Medical Council

Regulating doctors
Ensuring good medical practice

Death 2011

Dr Bawa-Garba 2015

Conviction suspended prison sentence

GMC

Public confidence

Medical Practitioners Tribunal 2017

12 months suspension "*erasure disproportionate*"

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GMC

General Medical Council

Regulating doctors
Ensuring good medical practice

Medical Practitioners Tribunal 2017

12 months suspension "*erasure disproportionate*"

GMC challenge in High Court 2018

Upheld – struck off

Court of Appeal Aug 2018

Overturned – remitted back to MPTS

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GMC

General Medical Council

Regulating doctors
Ensuring good medical practice

Court of Appeal Aug 2018

Overturned – remitted back to MPTS

MPTS Dec 2018

Extended 12 mth suspension to 18 mths

MPTS April 2019

Fitness to practice impaired through lack of face to face contact while suspended

Return to work July 2021

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GMC

General Medical Council

Regulating doctors
Ensuring good medical practice

<u>Some thoughts</u>

Benefit to patients?

Consequences to professionals

Does this help “culture of candour”

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