HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Patient safety and gross negligence manslaughter in healthcare, HC 1582

Tuesday 16 October 2018

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Watch the meeting

Members present: Dr Sarah Wollaston (Chair); Rosie Cooper; Johnny Mercer; Andrew Selous; Martin Vickers; Dr Paul Williams.

Questions 1 - 95

Witnesses

I: Sir Robert Francis QC, Barrister, Serjeant's Inn; Professor Pali Hungin, Working Group Member for Independent Review commissioned by the General Medical Council on gross negligence manslaughter in the medical profession, General Medical Council; Dr Suzanne Shale, Independent Consultant in Healthcare Ethics, Clear Thinking Consultancy; and Professor Sir Norman Williams, Author of Rapid Policy Review.

II: Keith Conradi, Chief Investigator, Healthcare Safety Investigation Branch; Charlie Massey, Chief Executive and Registrar, General Medical Council; Matthew McClelland, Director of Fitness to Practise, Nursing and Midwifery Council; and Mark Stobbs, Director of Scrutiny and Quality, Professional Standards Authority.

Written evidence from witnesses:

- Sir Robert Francis QC
- General Medical Council

Examination of witnesses

Witnesses: Sir Robert Francis, Professor Hungin, Dr Shale and Professor Williams.

Chair: Good afternoon and welcome to this afternoon's session. Before we begin, I and some of my colleagues would like to register personal interests for the record.

I am married to an NHS forensic psychiatrist who is also registrar of the Royal College of Psychiatrists. I have two daughters who are both junior doctors; one is training in obstetrics and gynaecology, and the other is in her second foundation year.

Dr Williams: I am on the medical register. I am a practising general practitioner. I am licensed to practise by the GMC.

Andrew Selous: I have two children who are trainee doctors, who have been quite exercised by this issue.

Q1 **Chair:** I welcome you all to this hearing of the Health and Social Care Committee to consider the implications for patient safety of the application of the law on gross negligence manslaughter and of professional regulation.

Before we begin, I would like to clarify that, although this hearing has followed on from the events that led to the prosecution of Dr Hadiza Bawa-Garba, in this session we do not intend to examine those or any other individual cases. The purpose of the session, and we echo the comments in the review led by Professor Sir Norman Williams, is to "support a just and learning culture in healthcare, where professionals are able to raise concerns and reflect openly on their mistakes but where those who are responsible for providing unacceptable standards of care are held to account. This will lead to improved patient safety." That is the prime purpose of this hearing.

I will start by asking those of you on our first panel to introduce yourselves and the capacity in which you are here today.

Sir Robert Francis: I am Robert Francis. I am a Queen's Counsel. I have practised in medical law for far too many years—about 40. I am now chairman of Healthwatch England. I am a member of the board of the Care Quality Commission. I chaired the Mid Staffordshire inquiries and the Freedom to Speak Up review. I should add, for the purposes of this hearing, that I am by no means a criminal lawyer, although I obviously have some familiarity with the law in this area.

Given the declarations of interest, I too declare that one member of my family is a practising doctor and another is a medical student. They are both exercised by the issues we are talking about.

Professor Williams: I am Norman Williams. Until 2016, I was professor of surgery at Barts and The London. I am a colorectal surgeon by training. I was a president of the Royal College of Surgeons between

2011 and 2014. I am still, just about, senior clinical adviser to the Secretary of State, on an ad hoc basis. I am chairman of the national clinical improvement programme and a non-executive director at St George's, on their board. As regards conflicts of interest, all my children and my wife are lawyers.

Professor Hungin: My name is Pali Hungin. I am emeritus professor of primary care and general practice at Newcastle University. Previously, I was the founding dean of medicine at Durham University. I was president of the British Medical Association in 2016-17.

I am here as a representative of the independent review of gross negligence manslaughter, and culpable homicide as it applies in Scotland, an independent panel set up by the GMC. The chair of our review group regrettably cannot be here for very pleasant personal reasons to do with the arrival of a grandchild, so I have been detailed on his behalf.

Dr Shale: I am Suzanne Shale. I work as an organisational ethics consultant, primarily in the healthcare sector, but more recently I have also started to work with the policing and voluntary sectors.

For the purposes of transparency, I put on record that I carry out research and advisory work for a wide range of organisations. At the moment, I am completing a piece of research for the GMC that has no particular bearing on the matters under discussion today. I chair the charity Action against Medical Accidents, but I understand from the Clerk to the Committee that I have been invited to come here today not as chair of AvMA but in my personal professional capacity.

I am also on the advisory panel of the Healthcare Safety Investigation Branch, as it is currently called. Again, I do not represent them. Keith Conradi will be here this afternoon. The last thing I want to clarify is that I am a doctor of philosophy and not a doctor of medicine.

Q2 **Chair:** Thank you very much. It is fantastic to have a panel with such a wide range of experience and expertise. Professor Williams, would you reflect on the key findings from your review of the application of gross negligence manslaughter in healthcare?

Professor Williams: Thank you, Chair, for giving me the pleasure of addressing you. One of our major concerns was what we heard about patients' families who had lost loved ones. Whenever that happens it is an obvious tragedy, no matter what the cause may be. We wanted to make sure that those families were in our minds as we went through our deliberations.

That said, the recent cases that we reviewed caused immense problems in the healthcare professional world, and I do not mean just doctors. It is very important that, even though I might sometimes stray and just say "doctors," I am not just talking about doctors. I am talking about all healthcare professionals.

Chair: Thank you for that very important clarification.

Professor Williams: One of the problems we found was that the fear this induced is a major problem with transparency. If you are not open, and are fearful of being open, about mistakes and errors, you are in danger of impeding patient safety because you are not going to learn. That is very important, and that was the evidence we heard time and time again. People were not reflecting on their practice because they were worried about that. I will come to that in due course.

If we just look at gross negligence manslaughter—the evidence we got looked a bit further than that—it is not common. One statistic that the Committee should keep in mind is this. We asked the CPS about the frequency of investigation and prosecution; there are approximately 30 a year, of which there is one prosecution. That is not a great success rate. It is obviously horrendous if you are up in a court of law, but it is also horrendous for a professional to be investigated for the possibility of gross negligence manslaughter. That is very important to bear in mind. It is not common, but when it occurs it creates enormous stress.

As you know, our terms of reference were not to look at the law. We were not about to change the law; we could not do that. We could make recommendations about changing the law, and people came forward saying that the law should be changed; culpable homicide, recklessness and all sorts of terms were introduced. When we actually looked at it, and looked at what had been clarified recently in some of the cases, we found that the law was appropriate and that the bar was high enough. The problem was inconsistency in the investigations and in how the law had been applied. We concentrated on trying to improve the consistency of investigations, not just by prosecutors but locally, which was quite important. We wanted to make recommendations about improving that.

As you can see from the report, we felt that there should be a clear exposition of the law as it stands now, and as it is being made more concise and understandable by various judgments, particularly in relation to Rose, Sellu and various other cases that have arisen. We also felt that the training of expert witnesses needed considerable improvement. We felt that it was very ad hoc and needed to be improved, and we have made recommendations about it.

We felt that there should be greater consolidation of expertise in the prosecutorial system. That refers to the police. These cases are not common. No police force will have to deal with many, so there should be a national, virtual specialist unit in the police. We also felt that the CPS ought to consolidate their expertise, although they told us that they have a specific unit.

Coroners are independent judges, and we recognise that, but we felt that advice to them ought to be consolidated so that it was consistent across the board. There should be consistency of the law applied by everybody dealing with these sorts of cases, and everybody appreciated that. When

a coroner is making a decision to refer to the police, they should refer to the memorandum of understanding on consistency of the law.

We felt that all those involved in investigations should understand the importance of systemic problems. Individuals work in a complex system. As some of you know, health is a very complex environment that has become even more complex. It is very important to place the individual, who may or may not be guilty or accused of gross negligence manslaughter, within that very complex system. Everybody should have training and understanding of that, with particular training and understanding of human factors.

Some cases start off with local investigations. We felt that local investigations in the trust should be tightened up. They should be consistent and professionally run. There is a thing called the serious incident framework being consulted on by NHS Improvement at the present time. We felt that that could be buffed up and improved, and have made various recommendations about that.

If there is to be an investigation of GNM, we recommended that there should be a parallel investigation looking at the system. We have interesting evidence from the Health and Safety Executive. When they investigate a death outside healthcare, they look at the system. That is the first thing they do. They do not look at the individual. They may say that an individual should be charged or looked at appropriately, but that is not how they do it first off; neither do the Fire Brigade for fire investigation. The individual is a secondary consideration; it is the system around them. That is why we recommended that there should be a proper systems investigation.

At first, we thought that should be done by the Health and Safety Investigation Branch, but it is still developing and would have to deal with a huge number of cases, so we recommended that the CQC should probably take it up. That is part of our recommendations.

We have dealt with the law. We looked at reflective material that was said to be used against individuals in court. In fact, we found that was very rare. Healthcare regulators told us that they would not use reflective material in their investigations of fitness to practise, but, interestingly, two of them, the General Optical Council and the GMC, have the power to demand it. Our recommendations say that they should have that power withdrawn. We felt that they should have that right removed.

When looking at the regulatory bodies, we made various recommendations. It is important to understand that it was not just about GNM; we had a lot of concerns around black and ethnic minority groups. In this arena, it is always difficult to find out the truth. You get the evidence you need, but there was no doubt in our minds that there were serious problems that needed to be investigated and redressed. We have made recommendations about how they could be redressed.

We felt that there should be more joint working. We understand there is legislation for the nine regulators. They all have fitness to practise rules and regulations embedded in law, but if they worked together a bit more maybe they could handle things in a better manner.

Finally, perhaps most controversially, after considerable deliberation and thought, we recommended that the fear that had arisen in relation to the GMC's right of appeal should be removed. People might be worried about that, but we felt that the Professional Standards Authority sits above all the healthcare regulators and has the power to protect the public, and indeed the professionals. Importantly, the GMC is the only one of the nine regulators with that right of appeal. That does not really send out a consistent message. As we said at the very beginning, we wanted to improve consistency across the board.

Chair: Thank you very much for that really helpful overview. We are now going to explore some of those themes in greater detail with you and the whole panel.

Q3 **Andrew Selous:** Professor Williams, I think you said earlier that you felt that the bar for gross negligence manslaughter in English law was appropriately high enough. Can you say why you think that is the case?

Professor Williams: If you look at recent clarification in the law by the judges and the judicial system, and you go back to 1994 when Lord Mackay laid this out, he said that when judging people in this situation they need to take into consideration all the circumstances. That sometimes has not been applied, in our view. That is one thing.

Later on, very recently, Sir Brian Leveson stated that the individual must be found guilty of being "truly, exceptionally bad," in poor performance, which is a really important statement, and that it was right for the jury to decide—not the judge and not the expert witnesses. It was for them to make the decision as to whether performance was grossly negligent. With those provisos in place, plus other bits and pieces around them, we felt it was appropriate. As long as the investigation is done appropriately and all those things are borne in mind, there should be far fewer investigations. Therefore, only people who are performing exceptionally badly, warranting a criminal sanction, should be before the court.

Q4 **Andrew Selous:** I am not a lawyer myself, but the Scottish law on culpable homicide talks about "utter disregard" and "recklessness". Those are two phrases that are used. Is there anything we could learn from Scottish law in this area? Robert Francis, as a lawyer, may want to comment on that as well.

Sir Robert Francis: I am not a Scottish lawyer, and I apologise for the late arrival of this note, which, in that regard, you should treat with some caution. It does not look to me as though there is unanimity that the Scottish solution is either better or necessarily very different from the English one. That needs further investigation.

The one thing that it seems to emphasise in terms of these issues is the state of mind of the defendant, and in this case it would be the doctor. The phrase is "utter disregard for safety" or "recklessness." Recklessness sends a shiver down the spine of any practising English criminal lawyer, because the case books are full of decades of cases where lawyers dispute what that means. I am not as familiar with the phrase "utter disregard for safety," but it seems to me, at first sight, to be a test that may well fit the bill. If one applied it to the facts of many of the cases that you and I have seen reports of, one would seriously wonder whether they would ever have reached the court.

As far as our law is concerned, I am afraid it is probably the one thing on which I respectfully disagree with Sir Norman and his report. The reason is this. I think the state that the law has got into is the reason why we have inconsistency of approach from prosecutors. In other words, if they, the investigators, do not understand precisely what the law means when applied to a set of facts, it would suggest to me that there is something wrong with the law. Further, if there is that uncertainty, where is the poor doctor or nurse meant to be in deciding the standard that applies to them?

The phrase "truly, exceptionally bad" in itself invites a subjective judgment, and, try as they might, and they will be directed not to, a jury will find it very difficult to avoid applying a retrospective judgment. Of course, the tragic death of a baby—it does not matter who—in circumstances where, in most cases, a doctor or nurse will have to admit that a mistake was made is truly, exceptionally bad in one way. It is a tragedy and it should not have happened. That is the first point.

The second point is that how "truly, exceptionally bad" is defined is that it is so reprehensible as to justify a conclusion that it amounted to gross negligence and required criminal sanction. Whether that is the intention or not, the jury will in effect understand that they are being asked to decide what is or is not a criminal offence. For instance, if a person is charged with theft, it is very easy to work out what the definition of theft is: you took someone else's property without permission, you did so dishonestly and you intended to keep it. Those are facts we can look at.

If you ask, "Is this so serious that it deserves criminal sanction?" you are asking the jury to make the law for a particular case. I would suggest that that is a flaw in the law. It probably applies not only to doctors and nurses but to all other forms of gross negligence manslaughter, but it affects that field more than most because of the complexity of the circumstances that surround a case.

Having voiced my disagreement with Sir Norman, I will go on to agree that, whatever the law is, it should focus on the surrounding context in which the medical practitioner is working, and there should be an understanding of how those circumstances impact on people's behaviour and their ability to make rational decisions in particular circumstances. In

my view, most of these cases go wrong, if they go wrong, because of lack of attention to that.

This is a long answer, but I again echo something Sir Norman said. No changes can be made unless they carry with them the confidence of the public, the patients and the bereaved families that they can trust that whatever is put in their place will provide them with the consolation, the remedy and the assurance they need that they have been told the truth, that everyone has accepted their responsibility for the awful things that have happened, and that everything possible is being done to stop them happening again.

Professor Williams: Could I add one thing? I do not want to disagree with my learned friend, but the important point we made was that doctors, nurses and healthcare professionals cannot be seen to be above the law. I think that goes to what you were saying. If we are going to change the law, it has to be changed across the piece; it cannot just be changed for medical gross negligence manslaughter, because there is no such thing.

Sir Robert Francis: I agree with that.

Professor Williams: Good.

Q5 **Andrew Selous:** Developing that a little further, to what extent do you think there is shared understanding across the legal and healthcare professions as to the bar required for gross negligence manslaughter? Are the two professions operating with slightly different takes on this?

Professor Williams: They have up to now, but, because the law has been clarified, we recommended that there should be agreement between all parties—in fact, we set it up—that they come out with a statement that is agreed between them, and that everybody understands exactly what the law means. I think that will go some way to help the situation.

Q6 **Andrew Selous:** How appropriate do you think the process of prosecution is in both protecting patient safety and making sure we treat healthcare professionals fairly? Do we have the balance right between competing interests?

Professor Williams: I do not think we have had the balance right up to recently, but, if the recommendations are pursued, we will get the balance right. That is where you come to the inconsistency and arbitrariness that is one of the problems. We have seen certain cases where we wondered why the individual was prosecuted. Colleagues of mine have said, "Well, I have made the same mistake. I could have been there." We have certainly had it wrong up to now, in my view and in the view of the panel. The recommendations are designed to try to improve that.

Q7 **Andrew Selous:** What do you think the key take-aways are from your recommendations in terms of improving patient safety?

Professor Williams: All the things I have said, basically: the recommendations on expert witnesses, the local investigations, and the freedom to be transparent about your mistakes and not be concerned that you will be indicted or investigated for gross negligence manslaughter. That is a difficult balance, but it is an important balance. Perhaps it is something you need to ask Keith Conradi, when he comes in, about HSIB. There is legislation proposed for a safe space. It is a difficult balance, but I think we need to move more to transparency.

After all, in my view, all healthcare professionals go to work every day to try to do the best they possibly can and to save lives. They need to be supported, but really bad behaviour needs to be sorted out. You have to get that balance right, and I think we have skewed it a bit too far at the moment.

Q8 **Chair:** We have just received the update from the Department of Health on their progress against your recommendations.

Professor Williams: Good. You know more than I do.

Q9 **Chair:** I was going to ask you whether you were happy with the progress that has been made.

Professor Williams: Thank you for that. Like all these things, you want it done yesterday. I cannot say that I am entirely happy with progress, but they are doing a reasonable job. Most of it is okay. The problem will arise around the legislation. I do not have to tell your group about the problems there. That is what I would worry about. Maybe that is something you want to explore with others, to ask what might be done before the legislation is enacted. There may be measures that can be taken.

Q10 **Chair:** Nobody underestimates the challenge of amending legislation in a hung Parliament. The thing that comes across from your report to me is that we need to apply it much more consistently. We will publish the Government's progress, but I wondered whether you yourself were happy with the measures they have taken to improve consistency.

Professor Williams: I am very heartened by the response we have had from the police, the CPS and all those groups. I would like the expert witness stuff to move forward faster. It is my view that, if you are an expert witness, you need to be trained appropriately. That does not occur now, and there needs to be support for people who do that. Trusts need to give people the time to do it, and it should be part of CPD—professional development—and seen to be really valuable. There should be greater effort because that is not going fast enough from my point of view.

Q11 **Chair:** That is the key area where you want to see greater action.

Professor Williams: It is one key area that I think could go faster.

Chair: Thank you for clarifying that. We are going to come on to the area

of systemic failure versus individual responsibility.

Q12 **Rosie Cooper:** I am sure we have all watched the NHS culture change from no blame to fair blame and to where we are now, which is the just and learning culture, where the first question should always be, "What happened?" and not, "Who did it?" In things I have been involved in recently, "Who did it?" has been the first question, and that does not really help anybody. Are the law and regulators too focused on determining individual responsibility, rather than establishing learning, for the sake of patient safety, what we can all do together for this never to happen again?

Sir Robert Francis: It is almost inevitable that that is what they do, because of the way they are set up. The regulations tend to require a complaint, which has to be about one of their registered practitioners, so they investigate the practitioner. I have made a recommendation or two about that in the past. It does not stop them investigating the systemic background to the individual, and in most cases it does not stop them proactively thinking, "There are a few other people out there we ought to be asking questions of as well." I am not sure they do that enough.

If you follow the route of sanctions designed to protect the public, there is a debate going on as to whether the current regime in professional regulation actually achieves that anyway. They spend a vast amount of their resources on a tiny minority of people who are alleged to be unfit to practise, and a tiny proportion on supporting the vast majority who would do even better if they had support.

The answer is that they do not do systemic investigation well, and they will continue not to do so when, as Sir Norman suggested, they do not co-operate with each other so that an overall picture develops of what the nurses, the doctors and the allied health professionals have done. The big influence on this is the leadership and management of the organisation.

I am not entirely sure how that can happen when all the separate regulators are pursuing their own particular hare. Frankly, I think there may be too many of them. One of my suggestions is that, if you had a common tribunal to deal with the concerns of all of them, you might get to a place where more of a common view was taken. You could have a nurse, a doctor and a manager in the dock at the same time, as it were.

The suggestion that the Care Quality Commission has a role in this is, if I may say so—I do not speak for them today—to be treated with some caution. They are not set up to investigate individual cases, but they have lots of information that they put in the public domain, and other intelligence that I am sure they would be happy to share, about how well systems are running or if there are particular concerns about them. I suggest that the professional regulators should look at that before deciding what to do about an individual.

Professor Williams: I will let others comment, but I think there has been a real problem with blaming the individual, and it has been historical. I would like to think that things are changing, and, slowly, they are changing. We are getting more openness, but there is still real fear. There is no question about that. I speak to junior doctors at St George's and elsewhere, and they tell me that they are still frightened. They are still not prepared to speak up. That is the only way to improve safety, as you are well aware. If you cannot admit your mistakes, you are not going to improve. You are not going to find out how to improve. We have a long way to go. I hope that our recommendations move things on somewhat, but it is the old culture problem. There are others here who are more expert than I am who could probably answer that.

Q13 **Chair:** Professor Hungin, would you like to comment?

Professor Hungin: I should point out that our review started in January this year and we will not report until spring next year. It is an in-depth review. We have built very much on Sir Norman's work, but there are certain important differences. We are specifically only looking at doctors, and we are covering all the UK nations. Obviously, we have the luxury of more time so our work is in greater depth and is on the entire range of situations, from early investigations to what happens after potential prosecution and conviction.

Perhaps I could read out one of our objectives: "To produce recommendations that will support just decision making and application of the law, procedures and processes where allegations of GNM/CH have arisen so that accountability is appropriately apportioned between healthcare systems and individual doctors." That is something we are very conscious of as we proceed with our listening exercise.

If you would allow me a moment or two longer, our terms of reference indicate that we want to consider GNM and culpable homicide in relation to the perceived vulnerability—this is important—of the medical profession to those charges, and to see what can be done to improve the application of the existing law. We also want to look at how the GMC should handle such cases in the future. That is an important part of our remit. As part of the review, we aim to encourage a renewed focus on a fair and just culture, reflective practice and individual and systemic learning. In our objectives, and certainly in our terms of reference, we echo much of what has been said by the previous two presenters.

Dr Shale: For me, one starting point is to think momentarily about what the purpose of the criminal law is. This relates both to the question about the threshold and to Rosie Cooper's question about individual responsibility and system failures.

We need to remember that, while the criminal law proceeds on the basis of individual liability, it serves a really important function in upholding standards that all are expected to comply with. Although we very often think about it as being about punishing individuals, at the point at which

individuals are held to account, it also sets out very clearly that all will be held to that standard.

Some of the discussion around the threshold for gross negligence manslaughter has focused on the potential injustice to individuals who are unfairly blamed, as it were. In some of the discussion, some of the doctors and other healthcare professionals I have spoken to come at this from a slightly different angle. They said, "We do work in difficult systems, in a system at tipping point, but it is then all the more important for us to uphold the standards it is possible to produce in the context of that system." The criminal law offers both professionals and members of the public a very clear sense that people will take responsibility for enforcing those standards when someone has fallen below them.

That takes me to the issue of systemic accountability. Like you, I have been very interested to witness the shift in the NHS from talking about a no-blame culture to talking about fair blame or a just culture. If we look at what is happening at the moment in the discourse around a just culture, the focus has been on treating fairly staff who become embroiled in incidents. I think that is absolutely right. There needs to be justice in the culture for staff who make an inadvertent error.

My question then is, if you find yourself working in a system where systems are failing, who do we count accountable for the systemic failures? This is one of the areas where we have a problem. We are importing some thinking from industries, such as the airline industry, where they have a safety management system that enables systemic issues to be addressed. One of the problems we have in the NHS is that systemic issues are extraordinarily difficult to address, particularly at individual organisational level.

I would like to say something later about investigations because that is an area I have been very involved with and have thought about a lot. The thing I really want to emphasise now is that if we move away from blaming individual members of staff inappropriately, which is right, we have to think very carefully about how we hold the system accountable; otherwise it ends up that no one is accountable.

Q14 **Rosie Cooper:** To develop that, the core of the question is how a balance can be struck between individual responsibility and systemic failures. Professor Williams talked about all healthcare professionals. Sir Robert included others, and you yourself have just talked about everyone, and said that standards apply to all. Yet every day we see individuals being held to account when the system is not held to account.

How would we develop a system that enabled that to be looked at with so many individual regulators, even if they are alert, awake and attentive? Often they are not; I can give a million examples. There are deaths in prison. We currently have three nurses before fitness to practise at the NMC, yet their immediate boss—a manager, absolutely involved—is still

at work, because they are a healthcare professional and nothing is touching them. That is outrageous, and it goes on in our name.

Yes, there is accountability in the individual and in gross negligence manslaughter with recklessness, but what about a system that is absolutely reckless and forces people into positions where they make mistakes, cover them up and, worst of all, do nothing? How do we fix that?

Professor Williams: This is where corporate manslaughter comes in and whether that can be applied. It is interesting to me. I understand that in certain cases there has been an attempt to bring a corporate manslaughter charge against trusts, but it is never successful. I think that is wrong. Yes, there has to be accountability, but you have to appreciate that when something awful happens it is very rarely one or two individuals in that system. There is a string of things. There may be individuals along the line, but if you are really going to get improvement you have to address the whole breakdown. It is the classical Swiss cheese thing.

Q15 **Rosie Cooper:** But if the system is not being held to account, how do you ever get there? This Committee will groan if I mention the Liverpool community trust, and I am not going to go there, but I can give you a file of the number of times I have referred people to their regulators and their professional bodies, and only on the third or fourth time of asking did they look at it, and only after the Kirkup report. Some of them had gone before that. Health professional councils took two or three goes. The GMC have only just woken up; I note they are here. It is hard to get anybody to actually look at it.

Those people were in control of that system. How can they walk away? How can five out of six chairmen and non-executives not give evidence to Kirkup? This is the system allowing it. Sometimes, a doctor or a nurse who is doing their best, in order to save a life, may also have to take a little risk within parameters. They worry daily about their jobs, yet, if you are taking home your good salary while sitting in a cupboard somewhere, it is okay. How do you make that fair across the piece?

Professor Williams: Sir Robert may be able to help you, because I can't. Seriously, Robert knows far more about the CQC than I do.

Sir Robert Francis: I think there are two levels to your question, if I may say so. One is the criminal law and why managers and directors are not held to account to the criminal law. The answer is almost invariably difficulty of proof of knowledge. Corporate manslaughter requires there to be a controlling/guilty mind—I am simplifying it. That is always going to be difficult.

If you come down a level, I have observed, as you have, that doctors and nurses find themselves in disciplinary trouble and are sometimes erased. Unless they happen to be registered as a doctor or a nurse themselves, the chief executive and the leaders get away scot-free. At some point—I

have suggested this in the past—we need to consider the regulation of at least senior managers or leaders of these organisations in order that their fitness is held to account in the same way as doctors and nurses.

Q16 **Rosie Cooper:** A fit and proper person test worthy of its name.

Sir Robert Francis: We have a fit and proper person test.

Q17 **Rosie Cooper:** It is not worth a carrot.

Sir Robert Francis: Well, it is worth a carrot, but as it is placed it is probably not the answer to the question you asked.

Q18 **Andrew Selous:** Reflecting on that, what lessons are there for investigators and prosecutors from the Healthcare Safety Investigation Branch model? Do you think the establishment of that body should have an impact on the way investigators and prosecutors conduct their business?

Professor Williams: It will be very important once it is up and running properly. It is at a very formative stage and, of course, the legislation has not entirely gone through either. I suggest that you ask the HSIB exactly that question. Their model can help and can reflect the improvements that need to be made at the local level. They cannot do it all, but they can suggest ways of improvement. I think that will develop. It will be very useful.

Q19 **Andrew Selous:** Reflecting on what you were saying, Professor Williams, about some of the junior doctors you have been talking to at St George's, I attended a meeting with the previous Secretary of State at one of my local hospitals a little while back. A senior surgeon there said that all his life he had always gone for it, in the sense that he had always been quite courageous, to the extent of his professional ability, in doing all he could to try to save his patients, but he was wondering whether he should practise more defensive medicine in the new environment.

Do you think that could be a serious consequence of where we are with some of these cases? There are cases that will never be investigated because there wasn't anything wrong, but there is a question of people not doing what they could have done, and what they felt they should have done, for fear of maybe going too far. Do you think that is a serious issue? Is it having a chilling effect on what we need surgeons and others to do?

Professor Williams: I speak as somebody who has done a fair amount of innovation in my time. It is always quite difficult and testing, because you are doing new things. Like all these things, if there is a proper structure around them, they can be improved.

We work within teams. It is very important that the team ethos continues and develops even more than it is now. If a consultant wishes to do something that is on the edge, it should be discussed within the team. If

the team is supportive of that as the only way of dealing with the problem—

Q20 **Andrew Selous:** Not a sole orthopaedic consultant. It is more the hub and spoke—the girth model.

Professor Williams: Absolutely. That is the right way to proceed. It gives you the support that you require to save the life, hopefully, of the patient when you are doing something that is just on the edge. We have all been faced with that sort of scenario; all doctors have, particularly surgeons, but not just surgeons.

Q21 **Chair:** A point that has been raised with me by doctors in training is that they feel that the airline safety analogy can only be taken so far. If your aircraft is not properly staffed, it does not leave the ground, but if your hospital is not properly staffed doctors have to continue working under very pressured circumstances. Do you feel there should be a mechanism whereby doctors can register on a regular basis when they are working in circumstances that they feel are unsafe?

Professor Williams: I could not agree more. It is impossible at times, and you have to carry on in quite testing circumstances. You need to be supported by the people around you—that is one thing—and to ensure that you have that support. It needs to be documented.

In one of the cases we looked at, and I am very well aware that I do not need to mention which case it is, if the individual had written down the problems he was facing on that particular day, he would not have been in front of a court of law.

Q22 **Rosie Cooper:** I have a final question about systemic failures. Professor Williams, you recommended that the GMC should lose its right of appeal. Why did you do that?

Professor Williams: We looked at that very carefully, as you might imagine. They got their right of appeal in 2015. The recent cases that have gone through, however, caused so much fear among the profession that we felt we had to do something about it. We looked at it in quite a lot of detail. There are nine healthcare regulators. The GMC is the only one with right of appeal. When we asked all the others whether they would want their own right of appeal, they said, "No way. We are very happy for the Professional Standards Authority to do that." There is a totally independent body that sits above all the regulators and has that power, so why should the GMC be the only one of the regulators to have it? We could not see the rationale. Again, it was from the consistency point of view, and the fear it had generated. That was the conclusion. There were other reasons as well.

Q23 **Dr Williams:** The difference would be that the GMC has a duty not just to protect the profession but to protect the public, whereas the tribunal did not necessarily have that duty to the public. Is that not why the GMC exercised it?

Sir Robert Francis: As a practitioner for doctors in front of the panel, the panel is still, although it is more independent than it was, a sub-committee of the General Medical Council. It has the duty to protect the public, and that is part of the guidance it seeks to follow. It is protecting patients and the reputation of the medical profession. It is not protecting doctors; it is protecting the reputation and the confidence the public have in the profession.

I would add a reason why they should not have a right of appeal to the one that Sir Norman mentioned. Given the relationship between the two bodies, the signal it sends out to the independent lay members who sit on a panel is that the body that actually pays them, albeit independently, and the body that sets the standards, is saying: "You got it wrong. You didn't follow what we, the prosecutor, said you should do." That is sending out a very peculiar message, whereas the PSA has a more independent role. Of course, in the case we are not talking about, their legal advice was, as I understand it, "You shouldn't appeal." Unless and until there is a tribunal that is separate from all of them, I suggest that they do not need, and should not have, a right of appeal.

Professor Williams: That is the two bites of the cherry argument, which I mentioned before. Very importantly, when we took evidence, I asked a member who had been on the council of the GMC in 2014, when they got the right of appeal, "Why did the GMC want the right of appeal at that time as the only one regulator?" The answer was, "Because they lack confidence in their own medical practitioners tribunal system." I thought that was very instructive, and the argument is, "Well, why don't you improve the tribunal system?"

Q24 **Chair:** Professor Hungin, you may feel it is too early for you to comment, but would you like to comment?

Professor Hungin: All I can say is that we have had a great number of feedback points, as you can imagine. We have had over 850 responses to our call for people's views. This particular area has certainly produced a lot of response. We have had a large number of roadshows. We are also commissioning independent research in relation to the public. We will just have to wait and see what the results of our deliberations are going to be. I am terribly sorry not to be able to give you any definitive responses.

Q25 **Chair:** It is nice to know what measures you are taking to explore this further. Dr Shale, is there anything you want to add at this point?

Dr Shale: Only that there is an argument that the Professional Standards Authority, which looks over all the professional regulators, would be the right place to locate right of appeal, so that it is consistent across the regulatory patch.

Chair: Thank you. We come now to the use of reflective material. A number of people have written to us to say that it is an area where there has been a chilling effect in the profession following the recent case. Paul

is going to lead the questioning.

Q26 **Dr Williams:** How important is it that healthcare professionals undertake reflective practice?

Dr Shale: This is one of the questions on which I have the least strong opinions. I am inclined to defer to other members of the panel, particularly if Professor Hungin would like to say something about it. One of the difficulties I have is that the reflective material I have seen has been fairly thin, and I wonder how far it is really a learning process that is of value to clinicians. I know they say it is, but it is a question that I would put to someone who is a medical educator. I will leave it there.

Professor Hungin: From the medical educator's viewpoint, rather than speaking as a member of the panel per se, yes, reflection is an important part of a doctor's progress. It is the way we learn about things that we could have done better, things that we were pleased about and how we can improve our own practice and respond to system problems if we can flag them up.

I mention as a personal point that it goes without saying that sometimes we forget that our key role is high-quality patient care and patient safety. Of course, we do not forget it among ourselves as doctors. In my view, reflection is certainly an important part of that life.

To step back into the role of review team member, one of our aims is to encourage a renewed focus on a fair and just culture, as well as on reflective practice and individual and systemic learning. Those are big challenges.

Q27 **Dr Williams:** We have taken evidence that engagement with reflective material has been affected by recent cases of gross negligence manslaughter. In some of their correspondence to the Committee, some doctors are adding a statement to their appraisal: "I shall no longer be able to reflect openly with regard to significant events. I want to express my anger and despair that a process that was intended to benefit me as a practitioner, and my patients through me being able to reflect and learn fully about any errors, has been hijacked by an adversarial court system for use in a fashion that was not intended."

Professor Williams: I understand that. We were always told to reflect in our appraisal. Appraisals are very important, and there is a part of that where you have to reflect on some of the things you may have got wrong, so I very much understand; but there are ways of reflecting without incriminating yourself. People need to learn how to do that. I am pleased to say that the Academy of Medical Royal Colleges, the GMC, and so on have now issued guidance around that, and you might want to explore it with the GMC when they come in. It was one of our recommendations, and they have pushed out guidance around reflection.

It is an indictment of the present system that somebody should feel like that, but it is true. That is why we also recommended that we remove the

right of the General Optical Council and the GMC by legislation not to demand reflective practice. We could not remove that from a court of law, from a legal perspective, and you will understand why; the CPS and the police made it quite clear that they had a right to look at any material. I do not think you could legislate if a crime was suspected.

Q28 **Dr Williams:** Do the other members of the panel agree that it is right that the regulators—the GMC and the GOC—do not have access to reflective material, but that it is right that prosecutions should have access to it; or should reflective material be legally privileged?

Sir Robert Francis: It is a difficult proposition to stand up that you should say, as a matter of law, that reflective material is inadmissible or not compellable to be produced as evidence in any circumstance. That would potentially be putting healthcare professionals above the law that applies to everyone else.

As I understand it, the CPS says that it would not in normal circumstances use it. There is a dispute as to the facts. There is some very wearisome analysis required as to what actually was done with reflective practice in the case that produced it. On the whole, my impression is that it is not the intention of law enforcement agencies to use it except in extremely exceptional circumstances. One of those might be if the reflective material showed evidence of a conspiracy to cover something up, for instance. Someone ought to be able to look at it for that purpose.

Should it be allowed to be given to the experts who are going to opine on whether something is truly, exceptionally bad? No, I do not think it should as a matter of practice. It is having a chilling effect on candour, on teamwork and on learning. The worst and most dangerous doctor is the one who never talks to his or her colleagues about things that have gone wrong and never develops any insight. Here you have a measure that is designed to make everything more open.

Do I think the regulators ought to be allowed to look at it? No, not without the consent of the practitioner.

Professor Williams: It can be very useful to the practitioner. I think that is what Sir Robert was hinting at. If you have reflected on mistakes you have made, it may well help you. What we are trying to say is that it should only be available if you, as the practitioner, give consent.

The HSIB legislation, which is similar to the AIB legislation, will put in a degree of protection.

Q29 **Dr Williams:** It will create a safe space.

Professor Williams: Precisely. It can still be put in front of a court of law, but only by going to the High Court.

Q30 **Dr Williams:** But that is only a safe space for HSIB investigations. It

does not create a safe space for personal reflection.

Professor Williams: That is right.

Q31 **Dr Williams:** Professor Hungin, do you think the only solution to this is for practitioners to learn not to incriminate themselves when reflecting?

Professor Hungin: It is a very difficult topic. We are going through a very sensitive period at the moment. In collecting people's views, we will get a barometer of where people stand on this particular issue. My personal view is not relevant. It is about how we, the reviewers, come out with our conclusions in a few months.

Q32 **Dr Williams:** There is the danger, is there not, that if the culture that exists continues, we will end up doing more harm than good?

Professor Hungin: That is a risk.

Sir Robert Francis: At the point when reflection should take place, which is pretty soon after any event, the doctor may have absolutely no idea whether what he says would be incriminating or not, particularly because, as I said earlier, the test of truly, exceptionally bad, even if applied sympathetically, can only be looked at retrospectively when a whole load of circumstances are taken into account. If one of those poor individuals took legal advice at that point, after a death, they might well be told that caution should prevail and not to say anything.

Q33 **Chair:** Is there anything else you want to add, or do any of the panellists wish to make a comment on a point you have not specifically been asked about but were hoping to be able to put across while here today?

Dr Shale: I hoped there might be the opportunity to talk about local investigations and some of the problems with them.

Q34 **Chair:** Please say what you would like to say about that.

Dr Shale: It is an important factor, and it is an area where I have done some work to look at the way in which investigations can include a more systemic approach. I echo the reference that Sir Norman Williams made earlier to the revision of the serious incident framework that NHS England is currently engaged in doing.

We have a huge problem with the quality of local investigations. The quality of those local investigations—

Professor Hungin: Do you mean consistency?

Dr Shale: No, I think it is the quality of local investigations. They feed into the culture of fear we are talking about. This is not to do with the quality of local investigations only into incidents where there may potentially have been gross negligence manslaughter, but the quality of local investigations more broadly, which then affects those done when there has been a death. People are looking to the HSIB to be something

of a silver bullet in improving the quality of investigations. I think there is a much larger problem than NHS England is endeavouring to deal with.

To refer to Rosie's question about the problem of the system, what happens with local investigations is that proximity—the person who happens to be holding the smoking gun, the individual healthcare practitioner—gets confused with causation. People see the cause of an event as being the last act by the nearest healthcare practitioner in line to the incident.

Alongside some of the issues that NHS England has identified, we need to recognise that there is a problem with NHS trusts investigating their own work. Social systems inevitably affect the ability to investigate your own employer and to investigate your colleagues. There are difficulties with hierarchy effects; people do not look up the system to say, "We are facing some fundamental problems, for example with workforce shortage, and those are not the responsibility of anybody on this ward or within this division." There are conflicts of loyalty to colleagues and to the organisation, which make it extremely difficult to do a balanced and objective investigation.

The work I was doing last year, looking at the quality of investigations in mental health trusts, suggests that the fundamental problem is that persistent organisational problems have become the organisational normal, so they do not get included as an issue in local investigations. The organisational normal are things like workforce shortages, poor estates and excess demand. That is the context in which people investigate an incident, but it is so manifestly obvious that that is the context that it does not go into an incident report.

Serious incident reports very rarely refer to those issues, because if you send up a report to the board that says, "The fundamental problem we have is workforce shortage," people think there is nothing they can do about it, and you are told that you need to make a recommendation that can be resolved at divisional level, or whatever level you are working at. There are problems with the serious incident framework and with the whole way in which we are placing weight on safety investigations in the NHS. Those need to be fundamentally rethought.

Q35 **Chair:** Thank you for that very important point. Do any of you want to add to that?

Professor Williams: What Suzanne is saying is absolutely right, but some trusts have got it right and we need to learn from them. On HSIB legislation, you might want to ask Keith Conradi when he comes in about how they might accredit trusts to run serious incident investigations.

Q36 **Dr Williams:** The current proposal is that they accredit trusts, although the pre-legislative scrutiny committee, of which I was a member, has made a recommendation that that does not continue.

Professor Williams: Oh really? I will be interested to know why.

Dr Williams: The Government are currently considering that.

Q37 **Chair:** The report is published. Why do you think they should?

Professor Williams: Why do I think they should accredit?

Chair: Yes.

Professor Williams: Because that is a really good framework.

Q38 **Chair:** You think it is the right framework to address the points that Dr Shale raised.

Professor Williams: It will help. We made recommendations about how the serious incident framework can be improved. It is a question of making sure. We would all want an independent chairman. We would all want each member to be fully trained so that it was done professionally, but you have to be practical as well. How easily will that be done across the piece?

At one point, we talked with the Secretary of State about different trusts crossing over and looking at each other. I do not know how far that has got, but it struck me as a possible way forward.

Q39 **Chair:** We will explore it with our next panel in more detail. Thank you for clarifying your views on it. Sir Robert?

Sir Robert Francis: First, I actually thought of the HSIB as the great hope for the spreading of good practice to local investigations and the setting of standards. Accreditation would be one way of doing that.

The point about local investigations, and I agree with everything that has gone before, is that one of the most important things, apart from independence, promptness and fairness and experienced and trained investigators, is the involvement of the family, in the case of a death, and in the case of a living patient, the patient. That is not only in the sense of, "Tell us what you think happened and what you think we ought to be looking at"; it is continuous involvement in the process of the investigation so that they, the most important people in all of this, have an almost real-time understanding of what is happening, so that when the result comes out there will be a better chance of them having trust in the outcome. At the moment, the investigations that happen often carry no trust or confidence with those who are aggrieved by what has happened.

Q40 **Rosie Cooper:** If I might comment on my favourite trust, they carried out investigations, and if the chief executive did not get the result she wanted, she had her prepared panel that gave her the result she needed. Everybody knew it, and it was as open as that. It is so important and it is terrifying. If that is the culture and the power at the top—it is not everywhere—this is really very important.

Professor Williams: Is she still in post?

Rosie Cooper: No.

Chair: We need to address various issues. That is very clear to all of us. Thank you very much to our first panel.

Examination of witnesses

Witnesses: Keith Conradi, Charlie Massey, Matthew McClelland and Mark Stobbs.

Q41 **Chair:** Welcome to our second panel. Would you introduce yourselves and who you are representing for those who are following from outside the room, as well as those who have joined us today?

Matthew McClelland: I am Matthew McClelland, director of fitness to practise for the Nursing and Midwifery Council.

Keith Conradi: I am Keith Conradi, chief investigator with the Healthcare Safety Investigation Branch.

Charlie Massey: I am Charlie Massey, chief executive and registrar at the GMC.

Mark Stobbs: I am Mark Stobbs, director of scrutiny and quality at the Professional Standards Authority.

Chair: Thank you very much. Dr Paul Williams will start the questioning this afternoon.

Q42 **Dr Williams:** Good afternoon and thank you for waiting. We are going to start by talking about reflective material, which is where we ended with the last panel.

We have been talking about the power to request reflective material and the recommendations from the Williams review. I will put the first question to Mark. Will regulatory bodies use practitioners' reflective material in an investigation?

Mark Stobbs: We do not see any reason why they should. Fitness to practise proceedings are about future fitness to practise. Usually, the proceedings are many months after the events. The practitioner will have had time to reflect further. From a prosecution point of view, it is very hard to see how reflective statements made at the time would assist a panel one way or another. There may be occasions when it should, but those will be very rare.

Q43 **Dr Williams:** You do not think they give an insight into the past thoughts of the practitioner, which might then give an indication as to their future behaviour.

Mark Stobbs: What we tend to see in the decisions is that practitioners frequently go on a journey, and your immediate thoughts frequently change as time goes on and you have further time to reflect.

Charlie Massey: From the GMC perspective, we do not ask for reflective notes in our fitness to practise processes. We clarified that earlier this year. As one of the former panellists said, quite often reflective notes can be a very powerful way for a doctor to demonstrate insight, remediation and remorse when something has gone wrong. That can often be a very valuable thing for a doctor in terms of informing the outcome of a fitness to practise process. While we will not require that from a doctor, quite often it will be in a doctor's interest to share that. That is not the only reason but one of the reasons why we share the anxiety that many doctors have expressed about the use of reflective notes and people's worries about the use of reflective notes in the criminal process. It was something you were talking about with the panellists just now.

Q44 **Dr Williams:** The GMC currently has the power to request reflective practice notes as part of fitness to practise.

Charlie Massey: We do have that power, and Norman Williams has recommended that it is removed. Because we do not use that power, I am completely relaxed about that recommendation going through.

You asked a really important question earlier. If it is not of use in an investigation process, what about the criminal legal process? Our view at the GMC is that reflective notes should be legally privileged in the criminal process as well. I say that not because I think that doctors should be above the law, but I have spoken to many lawyers over the last six months, who have emphatically told me that reflective notes have no evidential value in proving guilt of a serious crime, and as such I think it would be deeply symbolic to the profession—and not just doctors but other healthcare professionals too—if such notes did have legal privilege.

Q45 **Dr Williams:** Keith, you have obviously been thinking quite a lot about safe space in the context of HSIB's work. Do you have any view on whether or not reflective notes should be given that safe space privilege?

Keith Conradi: Bearing in mind that our process is not judicial at all—it is just for safety—when we take a statement from a witness we would want them to use all the information to hand. So, if they have made a reflective note, we would encourage them to use that in the statement that they make to us. It is all good evidence for us to build towards this safety case that we are trying to make.

Q46 **Dr Williams:** The GMC thinks that medical reflective notes should have legal privilege. From the nursing point of view, does the NMC share the view of the GMC?

Matthew McClelland: We do not have the power to compel people to provide information as part of our investigations, but, like others, we see that there is a fundamentally important role that reflection can play as part of the fitness to practise process, which is to be forward looking and to say, "Actually, I have reflected on what has happened here and what has gone wrong, and these are the steps I have taken to remedy that." That being the case, within our process there is every opportunity for us

to take that into account in thinking about whether any regulatory action is required.

When it comes to the criminal process, we do not have a particular view on whether there is a need for things to be protected. The key thing is to make sure that that important role of reflection within fitness to practise, albeit, as others have said, a voluntary role where the professional has the option to reflect, is maintained and not undermined in some way.

Q47 **Dr Williams:** Have you taken any steps in the NMC in the light of the Bawa-Garba case and in light of professionals' expressed concerns about how safe it is for them to be honestly reflecting?

Matthew McClelland: Absolutely. The Bawa-Garba case was ongoing during the process of us developing our new fitness to practise strategy launched in July of this year. We used the learning from that and the wider learning around gross negligence manslaughter to inform some of our direction of travel there. In that, we are very clear that we are seeking to contribute to a just culture in the sector. That is an absolutely fundamental principle, which requires professionals to have the confidence to be open to demonstrate learning with us and that we will take that into account, and also that we will work with them to encourage and enable them to review where there are outstanding areas of concern. It has been really important to us to take that learning into account in developing our strategy.

Q48 **Dr Williams:** Have you had to issue any guidance to nurses and midwives to stop them from incriminating themselves?

Matthew McClelland: We have not had to issue that. We are very clear that there is a privilege against self-incrimination. We provide that guidance through our standard documentation anyway, so we do encourage people to reflect. We are very clear that they do not have to talk to us if they do not wish to.

Q49 **Dr Williams:** From the GMC's point of view, you clearly encourage reflection. What changes have you made in order to reassure the profession about the safety of their reflection?

Charlie Massey: We committed very early in the year, very soon after the divisional court judgment in the Dr Bawa-Garba case, to produce new guidance on reflection. We were very keen that we did that in a very co-produced way. We did that with the Academy of Medical Royal Colleges, the Conference of Postgraduate Medical Deans and the Medical Schools Council, which we published just a few weeks ago. The importance of anonymising information to avoid some of the risks of incrimination was made very clear there. We are very clear in that guidance that courts can require reflective notes at the moment.

We are working with Matthew and colleagues around another piece, and we have begun conversations around team-based reflections. It is something that Sir Norman was saying earlier on. The way in which

healthcare professionals work together in complex environments and teams is really important to the question of reflection, because this is also about where things go well as well as when things do not perhaps go so well. We are committed with the other professional regulators to produce some more guidance and tools in the early part of 2019 dealing with that question of team-based reflection.

Q50 **Dr Williams:** Does the PSA have any views on how other professions can safely reflect without incrimination?

Mark Stobbs: The principles that the GMC and the NMC have described probably apply across the board. In a future performance review, we might well want to look and see how this goes to see whether we can produce any guidance or advice on that.

Q51 **Dr Williams:** Finally, would you agree that the current situation is one where, because of the reticence and the concerns that a lot of practitioners currently have, their ability to be able to reflect is being restricted?

Mark Stobbs: I think there is perhaps a bit of a difference between perception and reality. There is certainly a very strong perception out there that it is very dangerous to reflect and to record those reflections, and that it can be self-incriminating. The reality is somewhat different from that, but we have to deal with the perception as the reality. That is one of the reasons why we advocated legal privilege for reflective records. We think it would also send a very powerful signal to all healthcare professionals about the importance of reflection and its centrality to professionalism. It would give people more confidence to be able to reflect, knowing that those reflections could not be used against them.

Q52 **Chair:** Keith Conradi, do you want to come in on that?

Keith Conradi: Only to say that this has had quite an effect on people willingly speaking to us. I think it does come down to perception. We have tried to go into and speak to frontline clinicians in several trusts who have not spoken to us. In fact, the hierarchy in those trusts have recommended to their staff that they do not speak to us if we are recording that interview and have pointed to this case as the reason why.

Q53 **Chair:** Let me come back to that on a point of clarification. Why do you record your interviews? That in itself can lead some professionals to feel almost as if they are on trial. I just wondered why you record them.

Keith Conradi: One of the reasons is so that we can give a copy to the person we are interviewing as an absolute record of what was done there. Usually, we interview one or two investigators at a time, but it is a much wider team looking at investigations. So, other people need to listen to that interview to see if there is evidence from, say, a human factors perspective that they can get without having to re-interview that same person.

Q54 **Dr Williams:** Keith, just to clarify, that is even within a safe space investigation.

Keith Conradi: Yes, bearing in mind that at the moment, before any legislation comes in, we do not really have any powers. That is the concern, hence the need to have this legislation.

Q55 **Dr Williams:** You think the HSIB legislation may well help HSIB, but you are advocating going further and giving legal privilege. How do you respond to the suggestion that that puts doctors above the law?

Charlie Massey: It is the point that many lawyers have emphasised to me. Reflections are, by definition, things that happen after the event. In terms of a criminal process, they are therefore of minimal or zero evidential value in establishing criminality and guilt. It is on that basis that I was very persuaded that to provide legal privilege to reflective notes would not be to place doctors above the law. Robert Francis may have a different view, from what he was saying earlier, but that is certainly what many lawyers have told me.

Q56 **Rosie Cooper:** Mr Massey, can the GMC or you offer an explanation or justification for the decision to appeal the MPTS decision in the case of Dr Bawa-Garba on the basis of patient safety?

Charlie Massey: First, the death of Jack Adcock was obviously a very tragic case. It was also a complex case, as demonstrated by the fact that one decision taken in the divisional court was overturned in the Court of Appeal earlier this year. It was also an unusual case. There are very few doctors, fortunately, who are convicted of gross negligence manslaughter.

The reason I took the decision I did was because I had very clear legal advice at the time that the medical practitioners tribunal had got it wrong in law by reaching a different view about the culpability of the doctor that had been established in a criminal court. The Court of Appeal clarified that that legal advice was not correct, but that was the reason I took the decision I did at the time.

Q57 **Rosie Cooper:** It is fair to say that this Committee never ever envisaged a decision being taken in this way with regard to the MPTS decision making. Do you think that your decision to appeal and the decision making surrounding this case has affected confidence in the GMC?

Charlie Massey: There has certainly been a knock in confidence within the profession in the GMC. I want to emphasise that the decision was one that was taken in good faith. As regulators, we quite often have to make difficult decisions. It was entirely legitimate to consider whether or not there was a public confidence question, given that the doctor had a criminal conviction for gross negligence manslaughter. I believe that the decision I took was a reasonable decision with the evidence I had at the time.

The wider point about confidence is a really important one. We have been working incredibly hard over the last nine months to demonstrate our support for a profession that is working under intense pressure. The vast majority of doctors do a fantastic job despite the pressure under which they are working. That is why we asked Leslie Hamilton to lead the review that Pali Hungin was here talking about earlier on. It is why only last week we announced some work we are doing around bringing human factors disciplines into our training for all our case examiners and investigators, and a whole host more besides.

Yes, there has been an impact on confidence in the profession and in us as the professional regulator. It is our lot as a professional regulator sometimes to make tough decisions. I believe that actions will speak louder than words in terms of all of those things that we are doing.

Q58 **Rosie Cooper:** We have talked all afternoon about learning lessons. I would ask you what lessons you have learned from the decision making and this process. More importantly, will you give up the right to have an appeal, or will you wait for legislation to stop you being able to appeal?

Charlie Massey: There are many lessons we have learned through this process. The announcement we made last week around bringing human factors disciplines into our processes was a very important piece of learning for us. We have always taken system factors into account when we have made decisions around fitness to practise processes, but the systematisation and bringing more consistency into our processes by bringing human factors disciplines methodologies into it is a really important development.

We have also learned the importance of seeing through the vision that I want for the GMC to be an organisation that spends the bulk of its efforts supporting doctors rather than investigating them. That is a hard process. This Committee has been incredibly helpful in supporting our efforts to get legislation from Government to simplify the way in which we make decisions. There is a huge amount that we have learned and are continuing to learn from the case.

You also asked the question about the right of appeal and where we are around all of that. Norman Williams said earlier, and in his report, that the use of our right of appeal, which we only got at the end of 2015, has not been excessive. We have appealed about one in eight of the cases that we could have appealed. Of the fitness to practise cases we have appealed, we have been successful in 16 out of 18 that have concluded. Indeed, Norman in his report said that the use of our right of appeal has been proportionate and appropriate, and that a case could be made for it improving patient safety.

I believe that the evidence around the right of appeal is very strong. What Norman also said is that we should review our processes informed by a review that the PSA is due to undertake into our right of appeal, which we are very open to doing. It is probably for Mark to say exactly

where the PSA has got to in that process. Until the Government legislate to take our right of appeal away, I still believe that we have a statutory responsibility to take action if we believe that a judgment by the medical practitioners tribunal leaves a continuing patient safety risk.

Q59 **Rosie Cooper:** So, the learning has not been that great really, has it?

Charlie Massey: I would say there has been a huge amount of learning. We have also learned from the Court of Appeal judgment itself, which in effect set a higher bar or threshold for deciding where we use that right of appeal. I have not exercised that right of appeal since the Court of Appeal hearing. That is not because I made a policy decision but because I have been very cognisant of where we have actually got to in that legal process. I would say that we have learned a great deal and continue to do so.

Q60 **Chair:** To follow on though, what we heard from the Williams review and from Sir Norman today was that the power should reside with the PSA rather than with you. Perhaps I could bring Mark Stobbs in to respond to that point.

Mark Stobbs: Thank you. We would respectfully agree with the Williams review. We think that one of the principal problems with a regulator having the right to appeal its own tribunals is that effectively it is giving them two bites of the cherry.

Q61 **Rosie Cooper:** Rather like my former chief executive that I was referring to.

Mark Stobbs: In particular, there are elements where the regulator itself as a prosecutor may have made a mistake. We have the independence to bring that to the court. The regulator themselves could not. It seemed to us simply that there was a duplication here. We are in a position where we see all nine regulators. We can take an informed view across the professions that tries to be consistent.

We will be looking at the way in which the GMC's process for making decisions on how it exercises its right goes. We have a formal published process. We take legal advice. We have three decision makers before we do so. We publish our reasons, and we seek to be as transparent and clear in the public interest as possible. There may be some help we can give the GMC.

Q62 **Chair:** To clarify, Mr Massey, do you consult with the PSA before going forward when you are appealing a decision? If you do not, why not?

Charlie Massey: What happens—and Mark will correct me if I get this wrong—is that, where there is a tribunal decision, the PSA and the GMC will independently look at that case and will not share notes in terms of reaching a view. There can be only one appeal, so, if we decide to appeal, the PSA cannot appeal as well.

Q63 **Chair:** What I am trying to get at is this. Given that the Williams review

is unequivocal about this, why do you not take the approach that you will discuss it with the PSA and not appeal it unless the PSA is in agreement with you?

Charlie Massey: If the Government are going to proceed with removing the right of appeal, and I would remind you that this Committee was part of the advocacy for—

Q64 **Chair:** Indeed, but subsequent events have shown that there are problems with this. Clear recommendations have been made, and it would be possible for the GMC to consult with the PSA and not take this forward without its agreement.

Charlie Massey: Indeed, and we have been very actively thinking about how we would design such a process. Until we have designed such a process, I think it is really important to recognise that we do still have a statutory—

Q65 **Chair:** But would you not be better, while you are reviewing it, to listen to the very clear recommendations that have been made and leave the decision with the PSA until you finish that review?

Charlie Massey: Just to be clear, the recommendation that was made about our continuing use of appeal was that we should review that process informed by the PSA's review of the use of appeal, which has not yet happened. I am not here saying that I disagree with Norman's recommendation that we should review our right of appeal informed by that, but that first piece has not yet happened. My council is poised to have that conversation.

Q66 **Chair:** But given that you have heard the PSA's view here today, you have heard Norman Williams's views and those of Sir Robert Francis, would you not be better to at least suspend taking these cases forward yourself until you have conducted the review?

Charlie Massey: That is not the position we have taken. It is certainly something that I would expect to discuss with my council before making a policy decision here. I would remind you about the genesis for the appeal. In a separate place from here today, there is a very important conversation happening with Bishop James Jones and families affecting the Gosport independent review. In that case, Dr Jane Barton, who is at the centre of those issues, despite our appealing for erasure, was not struck off. The PSA's predecessor body decided not to exercise that right of appeal. We took the unprecedented move at the time to press release our dismay at that being the case.

We are not trying to stand in the way of sensible change, but we do need to make sure that we think that through properly.

Q67 **Chair:** No one is doubting here that there should be a right of appeal. The issue here is where that should lie.

Mark Stobbs: I would just like to make a slight correction about the Dr Barton case, which the PSA did consider very closely. We considered that the decision was insufficient. We sought legal advice from two of the leading counsel at the time. Their view was that we were highly unlikely to succeed in an appeal. As I recall, the release from the GMC indicated that it understood the very high legal bar that we faced then. I recognise that this Committee is not looking at that.

In terms of whether the GMC would like to talk to us about when it exercises its right of appeal, we are very happy to do so. There may be some practical points. It has 28 days in which to appeal. We have further time after that, but we would certainly be very amenable to fast-track cases.

Q68 **Chair:** To be absolutely clear, your feeling is that the right of appeal should lie solely with the PSA.

Mark Stobbs: Absolutely, yes.

Q69 **Rosie Cooper:** Mr Massey, I just do not understand what disadvantages or obstacles you see for the GMC in removing that conflict, being on the same level playing field as other regulators and allowing the PSA to do it. What is stopping you from doing something that, to me, is so patently sensible?

Charlie Massey: I am very happy for us to take that forward and give it consideration, as Mark described. I should just clarify one thing. The medical practitioners tribunal is a little bit different from other regulators. Unlike other regulators, the medical practitioners tribunal service, although funded by the GMC, operates independently. Its decisions are completely independent. It reports independently to Parliament.

Q70 **Rosie Cooper:** But you are getting paid by the boss.

Charlie Massey: If Dame Caroline Smith, who chairs the MPTS, was here, she would strongly take the view that she makes those decisions in a completely independent way and that she sees value in terms of the separation from the prosecution—

Q71 **Rosie Cooper:** But this is about all sorts of things—about the Nolan principles of being seen to be fair and without conflict. I do not understand what you could possibly see as the disadvantage in handing off the appeal part to a professional organisation. No aspersions are being made about anybody. It is like investigating yourself and just changing your own decisions, which is what I alluded to before in a really poor, dreadful organisation. Why can you not just envisage getting rid of that conflict and allowing somebody else to do it?

Charlie Massey: Let me be clear. I am not saying that we have been closed-minded and said, "We will never do this." What I was saying is that we were waiting for the bit of process so we could do the

recommendation that was made in the Norman Williams report. I think we will pick up with the PSA.

Q72 **Rosie Cooper:** How hard is it to just do? I know it is a daft question, but how hard is it? "We will consider it. Can you do it? Yes." Move it on.

Mark Stobbs: We can certainly do that. The problem might arise where we decided that we did not feel it was appropriate, but again this is something we could discuss.

Chair: Thank you. Rosie was going to move on to an issue that Robert Francis touched on in his evidence about the possibility of joint regulation, which is question 18.

Q73 **Rosie Cooper:** The question is about whether there should be collaborative investigation between professional regulators where a series of failures are identified. I would also like to include the PSA. You talk about your nine regulators, but what happens when human resources are really involved in those decision-making processes that are wrong? Do you deal with them as well? Do you engage with them?

Mark Stobbs: When you say that human resources are involved, what do you mean?

Q74 **Rosie Cooper:** Do you mean give you the context for it?

Mark Stobbs: Yes; that would be helpful.

Q75 **Rosie Cooper:** This was a Prime Minister's question of mine also. For example, Liverpool community trust underspent by £2.8 million on district nurses. Therefore, those nurses were out there on the frontline really exposed. Everybody from the medical director down to HR knew. You are going to deal with the nine regulators, but who deals with these peripheral people such as HR and finance who enforced those decisions? I will come back to how the other members of the panel deal with it.

Mark Stobbs: The answer to that is that our powers do not extend there. They extend only to the nine regulators. It is clearly a question for Parliament as to how far you want to regulate yet more people in the system. We have been absolutely clear in our work that the present system is not fit for purpose and that it does not take adequate account of the team. There is certainly scope for regulators to work together, particularly where you have registrants from different regulators involved in the same events.

Q76 **Chair:** So in future you might have joint hearings.

Mark Stobbs: We would regard that as something that would be very positive to explore.

Q77 **Chair:** Do you have the powers to do it or would you need other powers?

Mark Stobbs: We do not have the powers to do it. It would need to be the regulators dealing with that. Charlie and Matthew will be better

placed than I am, but I suspect the legislation would cause problems there.

Matthew McClelland: This starts in a way before regulation. There was talk earlier about the quality of local investigations. It is absolutely critical that the quality of local investigations is consistent. We see from our work that there is scope for improvement across the sector. The reason why that is so important is precisely what was being articulated earlier, which is that the fundamental question that needs to be asked at the outset is, "What has gone wrong and how has it gone wrong?", and not, "Who is to blame?" That is much more easily asked at the local level.

When it comes to professional regulation, we are working at the moment on thinking through how we take a much more holistic approach to considering system errors and the context in which things go wrong. As colleagues were saying earlier, we are regulators of individuals, and it is therefore really important that from the outset within organisations the quality of investigation is right and it sets off on the right foot so that things do not come unnecessarily to us in the first place.

On the point about how we work together, we can and we do collaborate in a whole range of different ways. Where we believe that something is not a matter for us but is a matter for another regulator, we would contact them and pass it over to them. In some circumstances, as the GMC and we have done relatively recently, we collaborate on the investigation itself. We get together at the outset to say, "What do the circumstances look like here, who needs to be interviewed, and how shall we go about doing that?" We actually collaborate on the practicalities of the investigation itself. That is possible within our existing legislation. What is not possible within our existing legislation, and where legislative reform could potentially be extremely helpful, is in terms of joint adjudication. That simply is not possible and would require reform.

What I would also say on legislative reform is that—

Q78 **Chair:** Let me stop you there because I did not hear what you said. You thought that legislation could be helpful in which cases?

Matthew McClelland: When we get to the adjudication stage. Currently we cannot adjudicate cases jointly. Even where we investigate things together, the doctor would need to be adjudicated in front of the MPTS, and a nurse or a midwife would need to be adjudicated in front of one of our panels. It simply is not legally possible to do that jointly at the moment.

The final area where regulatory reform would be helpful is in bringing more consistency throughout the fitness to practise process. We do all nine or 10 regulators, including Social Work England, and indeed another three that operate in Wales, Scotland and Northern Ireland only. We all have different legislation, which makes the practicalities of collaboration more challenging than is perhaps necessary. Bringing forward some

legislation that introduced commonality and gave us a common basis would be extremely helpful.

Charlie Massey: I do not think there is any shortage of will among regulators to collaborate. Certainly, there have been lots of things we have been doing together very well, such as the way we train panellists and so on. There is quite a lot of collaboration in the investigation piece, but we have nine or 10 different sets of legislation that govern each of those professional regulators, which makes it quite difficult to achieve the true benefits of more genuine joining up and collaboration.

I have a couple of other points on this question. While Mark is absolutely right that our powers and jurisdiction relate to our registrants, for the GMC and other regulators too, we are very conscious that the context within which doctors work takes us into the territory of engaging with some of those wider systemic factors that are behind some problems and issues that end up coming through our door. That is why, building on our own investigation processes in terms of human factors, I want the GMC to play a significant role in supporting employers' responsible officers—the senior clinicians locally—in those factors.

It is also why we, with other regulators, are engaging better and more regularly with the system regulators—so, the Care Quality Commission, NHS Improvement and others—to try to use our data to be a bit more predictive and anticipatory about where things might be going wrong and to take action at an earlier point in time. I think that is really important. For all of us, while we are very aware of where our formal powers begin and end, we are getting into the question of workplace and systems more and more.

Chair: I am conscious that we might be having a vote shortly. There are a couple of important areas I would like to try to cover. I am going to come next to Johnny Mercer.

Q79 **Johnny Mercer:** One thing that interested me on this is how BAME professionals are referred for fitness to practise seemingly a lot more than other colleagues. Why do you think that might be?

Charlie Massey: The question of BAME doctors coming through our processes is something that worries me a great deal. We have very consistently audited our own processes to see whether there is any discrimination or bias within them. While all of those audits have not found discrimination or bias, it is not something I am in the least bit complacent about. We will have another audit of our fitness to practise processes next year.

I will give you two facts that I think are quite disturbing. One is that if you are a BAME doctor you have a 10% chance of being referred to the GMC by your employer. If you are a white doctor—and this is from 2012 to 2017—you have a 5.5% chance. You are proportionately nearly twice

as likely as a BAME doctor to be referred to us as a professional regulator.

I will add another fact to that. Complaints that come to us from employers are much more likely to end up in an investigation. A complaint from an employer has an 84% chance of being investigated, whereas one from the public has more like a 16% chance of being investigated. Those employer investigations are five times more likely to lead to an investigation. If you compound those two numbers, you end up with a very significant disproportionality of BAME doctors coming through our front door. I think that is something that is incredibly worrying.

That links to the point I made about workplace. I believe we have a responsibility in the GMC to understand what is going on in driving that disproportionality coming through our front door.

Q80 **Johnny Mercer:** That was going to be my question. What are you looking at doing to address this?

Charlie Massey: We have asked Roger Kline and Doyin Atewologun. You might have come across Roger Kline. He wrote about the "snowy white peaks" a few years ago. He is very credible and independent. He has written a lot about BAME staff across the NHS. We have asked him to do a very deep piece of work to look at what is going on. Importantly, we have also asked him to look at the places that are doing this right. Where are the places where we do not have that disproportionality coming through our front door? I am sure this is an issue that applies as much to nurses, midwives and other healthcare professionals as it does to doctors. My hope is that Roger will come back with some sense of good practice that we might be able to disseminate more widely across the NHS. It is something I do not think the NHS is generally terribly good at.

Q81 **Johnny Mercer:** Does anyone else on the panel have any thoughts as to why those pretty clear figures around BAME people being referred could be there?

Matthew McClelland: I do not think I have an answer to why, but exactly the dynamic that Charlie has described in relation to doctors exists in relation to nurses and midwives as well. We see a disproportionate number of black and minority ethnic nurses and midwives being referred into the fitness to practise process by employers. As a consequence of employer referrals progressing further through the system, black and minority ethnic doctors also progress further through the fitness to practise system.

We did some research in 2016 looking at what our data and some of the literature around it was telling us. That has been a key part of the evidence that formed the basis for our new fitness to practise strategy, which, similarly to what Charlie is describing for the GMC, puts more of an onus on us, working with employers to understand what is going on

and working with them on what the characteristics are of a good investigation locally and the characteristics of a good quality referral when it comes to the NMC, in a way that tries, as far as possible, to eliminate bias and discrimination where that exists. It is, however, an enormously complex picture.

My understanding, looking across other regulators where they have done research on fitness to practise outcomes, is that one sees a similar disproportionality.

Q82 **Johnny Mercer:** Outside of medicine.

Matthew McClelland: Within the healthcare profession. It is a very knotty problem.

Q83 **Johnny Mercer:** What lessons could investigating and prosecuting authorities learn from the Healthcare Safety Investigation Branch model for looking at failures more widely?

Matthew McClelland: We have worked closely with HSIB since it was set up because we have been very keen to establish a complementary way of working together. Clearly there is a lot of expertise invested in HSIB. It is really important that that expertise can be used widely across the sector within organisations. The one thing that we are all agreed on is the need for a just culture. I think we all fundamentally agree on that point. We have started very clearly aligning what we are doing and saying to that principle, and are absolutely committed to that.

Where perhaps we have had some anxieties in the past around HSIB's national investigations has been around the safe space and the effect that that potentially has on our own investigations. We have reached a place where we are comfortable with each other's respective roles.

It is more than semantics, but I think there is a risk around safe space being seen as an HSIB thing, but actually everything else is somehow perceived as an unsafe space. We are very clear that it is in the interests of patient safety for people to be open about what has happened, to demonstrate learning, and to work with us on remediation where that is necessary. That requires people to have confidence that they can talk to us, and that somehow there is not a safe space that is operated here and an unsafe space that is professional regulation. I do not think that is right and I do not think that is what HSIB intends.

Q84 **Chair:** It would be very helpful to have your comment on that, Keith Conradi.

Keith Conradi: Again, we do not have any powers at the moment, so we have to encourage people to speak and we just tell them that we will not voluntarily disclose information that is given to us. That is as far as we can go until some proper legislation comes through. We have spent a long time in the preamble to any interview explaining what we can protect, but, also, if they give us information, there is no immunity to

what they are saying to us. We are obliged to pass on anything that we think is a serious ongoing safety risk. We go through that and then we take the interview. Most of the time, by the time we have people to the table, they are very comfortable to speak. The problem we have is getting people to the table in the first place.

Q85 **Dr Williams:** Keith, I would like to follow up on some of the things that our previous panel talked about before you came into the room. We were talking a lot about the need for investigations at a local level of systems rather than individuals. Both Robert Francis and Norman Williams talked about the local investigations and the role of HSIB in local investigations. What are your current thoughts about the role of HSIB in local investigations?

Keith Conradi: Whenever we go in with a national investigation, we engage with the local team, who will probably already have looked at that reference event. There is an element of talking to them and helping them understand the way we would do it. There is trying to be that exemplar in that particular situation.

We are very keen to develop the role of professional healthcare investigator as per the Joint Committee's recommendations. We feel that this is the way ahead rather than the accreditation. We like that, and we are trying to put together an education team that will identify the type of training, the sort of courses, the standards and the criteria that make a very good local investigator and beyond.

With the maternity section, which is different again, we are now taking the place of some serious incidents, but we are working with the local team so that we do most of it together. As we are seeing information and evidence being produced, the local team see it as well. They will still be left to do their own investigations—we are only doing a small cohort—but they will have had a chance to see the way we do an investigation. This will be in every maternity trust eventually throughout England. Bear in mind we have the time because we are full time and professional. We are separate; we are not part of that local trust. We do not have all the problems that a local team has, which I know has been previously talked about.

Q86 **Dr Williams:** In our previous panel, some of the particular cultural difficulties that exist when an organisation is investigating itself were very clearly identified by Suzanne Shale.

Keith Conradi: That is right. You could have the most professional and well-trained investigator in the world, but if they are part of that organisation that will always be a problem. As events become more and more serious, there has to come a point where you go, "Do you know what? This needs somebody from outside the organisation to do an investigation that will bear scrutiny in the wider arena."

Q87 **Dr Williams:** My final question is, in the future, who will those

investigators be? If they are not HSIB and they are not CQC—because it is not really the CQC's role to do those investigations—who will do those investigations of systems?

Keith Conradi: I do not know. We are fairly limited in what we can do. Potentially, you could look at a slightly regionalised team. As long as you are taking them outside that trust, you will have some of the advantages of independence, but independence is critical.

Q88 **Dr Williams:** I am really going to push you on this. A regional team working for whom?

Keith Conradi: I really do not know. I think that landscape has yet to be determined.

Q89 **Dr Williams:** Does anyone else have any views on who can do system investigations at a regional level? Who has the independence but also the credibility?

Charlie Massey: I cannot necessarily answer that question directly, but I can give two observations that might help. One is that the CQC is stepping more into that territory at the moment. It is taking a greater interest in looking at local health economies. Certainly, its state of care report last week talked about more of an integration lottery than a postcode lottery. It talked about the difficulties of systems talking to each other.

The other point I would make is that most of us in the regulatory world are increasingly investing more resource in forming a local and regional view about what is going on. We have done a huge investment in our field forces. We engage with 40,000 doctors and medical students each year. A lot of the conversations I have had are about how we can create better conversations locally and regionally. It is not who is in charge but how we can pool data and intelligence at a regional and system level that enables there to be a more collective regulatory view. We have a kind of regulatory soup, as we all know, within the NHS. How we bring those perspectives together is potentially hugely valuable to whoever might sit in that plum seat.

Q90 **Chair:** I want to clarify one point before we move on. I am sure, Mr Conradi, you have seen the draft Health Service Safety Investigations Bill and the report from the Joint Committee. One of the points that it raises is that HSIB must be a new, independent and separate capability. It says that making it also a regulator of an accredited trust would confuse its role and make it part of the system that it is investigating. Do you agree with that assessment?

Keith Conradi: I do.

Q91 **Rosie Cooper:** I want to go back a little bit. We talked before about collaborating on investigations but not determinations. Mr Massey and Mr McClelland, what were the distinguishing features between the cases

against Dr Bawa-Garba and Ms Amaro that led to the doctor being suspended and the nurse being struck off? What are the distinguishing features that led to that and what is the difference?

Matthew McClelland: The Dr Bawa-Garba piece is probably more widely known. There is quite a narrow technical point that is about the timing of the hearing. Case law suggests that, while somebody is still subject to an unexpired criminal order, the order that the regulator imposes should not be shorter than the criminal order. At the time that Nurse Amaro came before our panel, she still had longer to run on the criminal sanction than we would have been able to impose by way of sanction. In a very narrow technical sense, a suspension—a lesser sanction—was a route that was closed off to Nurse Amaro.

My view generally on these two cases is that the GMC and NMC treated them relatively consistently. Charlie will, of course, talk about the GMC case, but he has already said that the history of the court findings around Bawa-Garba demonstrates how complicated and how finely balanced it was as a case. I do not see this as an example where the regulators have treated the professions radically differently.

Mark Stobbs: I think I would agree with that. If the original tribunal had decided to erase Dr Bawa-Garba, we would not have batted an eyelid. Our point was that there is a range of reasonable sanctions that a tribunal can come to. The MPTS decided that there was sufficient remediation, insight and mitigation for this to not be the final sanction. The courts have basically restated the law that you defer to the findings of the panel.

One thing that came out of the Williams review was a recommendation that we should look at consistency between regulators. We are beginning to have talks with academics about a research project that could try to identify whether there are any inconsistencies or systemic—

Q92 **Chair:** In other words, a similar panel could convene that could have looked at system issues in the case of Nurse Amaro.

Mark Stobbs: I am sorry?

Q93 **Chair:** A panel could have looked at the wider system issues before taking a decision to strike off.

Mark Stobbs: Indeed; yes, absolutely.

Q94 **Chair:** That is currently not available to you at the NMC.

Mark Stobbs: No. I believe the NMC could have dealt with that, and we frequently see it doing so. But it is the weight.

Matthew McClelland: Indeed, in the Amaro case the panel took into account the submissions on the context. It concluded that, none the less, having heard what Nurse Amaro had to say in the context, erasure was the right sanction. What I was describing earlier is us going into a more

systematic space throughout our process from start to finish, where we are able to make sure that we are properly and systematically taking account of context in every case.

Charlie Massey: The points I would like to make, very briefly, are, first, because both the Nurse Amaro and Dr Bawa-Garba case followed a criminal process, there was not the same investigative process that we have described before, where there is much more scope for collaboration. In effect, the medical practitioners tribunal, the NMC's panel, was dealing with the ramifications of that criminal conviction in terms of the judgments that it then made. I do not disagree with anything that Matthew and Mark have said about there being perhaps less difference than might first seem to be the case.

Rosie Cooper: Obviously it is not for today, but if you have two minutes could you think about how your investigations and collaboration can fit into this systemic bit? There is an awful lot going on outside of that which feeds in and helps to cause those problems. That is really not addressed. I cannot find a way anywhere. Working with NHSI, we are looking at fit and proper practice. There is a QC involved in doing that. How do you look at those outside bits that are beyond the health service but without which the health service does not function?

Q95 **Chair:** Finally, Keith Conradi, with your very important new role and having listened to all the evidence this afternoon, do you have any points that you would like to make to this Committee about how we arrive at a just and learning culture, and what your organisation will hope to add to this process?

Keith Conradi: I think it is really important that a safety investigation is involved with all these big cases. I really would like to see it rolled out more widely in whatever form that might be. Of course, there will be a need sometimes for parallel investigations to go on. That happened in my previous sector, and that is all part of the process. If we can start to put the emphasis on the safety investigation, therefore the systemic learning gets put into practice. That is the way that these events will drop off in the future rather than going through the judicial route time and time again.

Chair: Thank you to all of you for coming today. Are there any further points that any of you feel you have not been asked about that you want to make today? If not, thank you.