**Medical Defence Union response**

**Questionnaire: written submissions to inform Dame Clare Marx’s review of gross negligence manslaughter and culpable homicide**

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

**What factors turn a mistake resulting in a death into a criminal act? What factors turn that criminal act into manslaughter or culpable homicide?**

Taking both these questions together, a fundamental difficulty for doctors involved in any police investigation following the death of a patient is that it can take a very long time indeed to decide whether what has happened may even amount to a crime, or at least give rise to a prosecution. When an unexpected death is referred to the police on the grounds that a crime may have been committed, the police feel obliged to undertake investigation, at least in part because of the potential seriousness of the accusation.

Given a lack of familiarity with medical matters, and especially with a referral from a coroner (in the MDU’s experience the main source of referral), the police are likely to feel obliged to review a matter in some significant detail. It is by no means unusual to find that a police investigation in relation to the possibility of GNM in a medical context takes a year and more, and sometimes up to 3 years. A significant delay in an investigation is damaging for the healthcare professional and the family of a patient who, because of the preceding investigation, may be unable to have any hearing through an inquest for a considerable period.

The MDU’s experience (our in-house legal team specialises in assisting MDU members with criminal investigations) is that we see fewer than 1 doctor prosecuted for every 10 investigations. We recognise that the incidence of investigation will inevitably exceed that of prosecution, but such a ratio of investigation to prosecution is far too high. This has to be taken in conjunction with the very significant repercussions which are often experienced by the doctors under scrutiny, their colleagues and the trust in which they work as well, of course, for the families and those who were close to the deceased patient.

To establish an offence of gross negligence manslaughter, it is necessary for the prosecution to show the following:

1. The existence of a duty of care owed by the potential defendant to the deceased;
2. Breach of that duty;
3. That the breach involved a serious risk of death, obvious to the reasonable person in the potential defendant’s position at the time of the breach;
4. That the breach of that duty was a material contribution to the hastening of the death;
5. The negligence established from i-iv was in all the circumstances so bad as to be considered gross and thus a criminal offence.

For some time, the MDU had serious concern at the potential for a significant variation in how a trial judge might describe the nature of the failing required at v above. The formulation in *Adomako* did not require a specific descriptor, likely in part as the fundamental issue to be determined was the question of whether objective recklessness was sufficient to establish guilt. The recent Court of Appeal decision in *R v Sellu* now makes plain that a description consistent with that used in the case of *Misra* or *Kokkarne* is required to ensure a jury is aware of just how truly exceptionally bad a defendant’s conduct must have been to establish criminality, and that even very serious errors of judgement are nowhere near enough.

The MDU’s view is that the law as it stands today is better than in recent times in terms of providing clarity about how a jury should be properly directed. However, the problem for doctors is not just with the courts but very much with the procedures that precede a decision about prosecution, with such a high proportion of cases being investigated unnecessarily. Significant distress is caused through the lengthy investigation process, irrespective of the outcome. Even when prosecuted, most case result in an acquittal, suggesting that CPS decision-making may need to be better assisted by experts. Gross negligence manslaughter should only be prosecuted in cases that are the medical equivalent of a person knowingly driving down the motorway on the wrong side against oncoming traffic.

The MDU’s experience is that it is not the law itself that is fundamentally at fault, but there may be a concerning lack of understanding of the seriousness of gross negligence manslaughter among those who refer cases to the police. The guidance available to coroners is significantly lacking, and there is also a clear lack of explanation to the police in the current *Senior Investigating Officer guidance*. Experts instructed by the police to give an opinion may be similarly hampered if the police do not provide them with an adequate and clear explanation of the law.

We are not advocating a change in the law because we believe the law is clear that there is a very high threshold before the offence of GNM can be engaged. Beyond that, even if it were possible to bring about a change in legislation when there is no parliamentary time for the foreseeable future, there are too many unknowns; we do not know how any future law would be drafted, nor how it would be interpreted and have grave doubts it would be any improvement on the current position. For example, in 1996 the Law Commission put forward the offences of reckless manslaughter and killing by gross carelessness. The draft legislation proposed by the Law Commission had necessarily limited language, and gave none of the existing emphasis (through *Misra* etc) of just how bad something has to be to be found criminal. We are concentrating instead on suggesting improvements in the current procedure that need no legal change and that won’t require any additional financial support. We set out our concerns and proposals for change in these respects in our submission to the Williams Review. Many of these proposals were reflected in the Williams Review’s recommendations and we attach a copy of our original submission which puts our proposals in context.

In Scotland we know of no case where a doctor in the course of clinical practice has been prosecuted for the similar offence of culpable homicide. While the Scottish offence is strictly different from GNM, in practice it has similar components, and would be likely to amount to a significantly similar threshold. The lack of prosecution in the context of healthcare provision suggests an appropriate consideration of the threshold by the Scottish prosecuting authorities. We believe the same approach should apply in England and that investigation and prosecution of healthcare practitioners should be reserved for only the worst cases.

**This section focuses on the experience of patients and their families**

We believe families and others close to patients are in a better position to provide views on this section, however we refer to our response to the preceding question, that delay through police investigation of potential GNM may result in a family having to wait for a considerable period before an inquest takes place. It must be right that a police investigation should have precedence, but it begs the question whether such investigation genuinely serves the interests of those involved in and affected by it.

**Do the processes for local investigation give patients the explanations they need where there has been a serious clinical incident resulting in a patient’s death? If not, how might things be improved?**

**How is the patient’s family involved in the local trust/board/hospital investigation process and in feedback on the outcome of the investigation?**

**What is the system for giving patients’ families space for conversation and understanding following a fatal clinical incident? Should there be a role for mediation following a serious clinical incident?**

**How are families supported during the investigation process following a fatal incident?**

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

**This section focuses on processes leading up to a criminal investigation**

**Do you think that the current arrangements for reporting and investigating serious clinical incidents within healthcare settings are effective and fair? If not, what is wrong and how might they be improved?**

While there are clear legal requirements to report to CQC specified incidents, including unexpected deaths, which trusts and primary care practices adhere to as far as we are aware, we have not experienced much consistency in the way in which unexpected deaths are investigated throughout the UK. Some trusts do it well. Their procedures are demonstrably effective and fair, and doctors report feeling supported and valued, rather than stigmatised and persecuted: but many trusts do not do it well, and occasionally do it badly in one or more areas.

Please note that our comments below are provided in answer to specific questions about and rely on our experience in assisting members with investigations in NHS trusts. However, many of the problems we identify with current investigatory processes and the recommendations we make for improvement could be applied to primary care. Unexpected deaths are infrequent in primary care but they do happen, as do inappropriate investigations of GPs for gross negligence manslaughter, albeit not on the same scale as in trusts. We believe the same principles of fair and transparent procedures should apply so that NHSE teams seek initially to investigate and learn lessons, rather than to apportion blame.

That is not to say that no doctor should be held accountable, but there are separate procedures where such decisions can and should be made.

The sorts of problems that arise with investigations are often that the clinician investigator or the expert do not have appropriate clinical knowledge and experience, or that there is an obvious or perceived conflict of interest. It is not always a given that the doctor under scrutiny has the opportunity to provide full evidence and too many doctors aren’t aware of criticisms that are made of them or given an opportunity to comment before such criticisms are included in the final report. Sometimes doctors don’t see the investigation report until after it is finalised, even if such a report is passed to the police.

In many trusts the investigation carries on for a prolonged period because, for example, those who are investigating have other jobs that take precedence, or because they don’t do it very regularly and are not very experienced. In some trusts not enough time is set aside for the investigators to take evidence from witnesses and participants and the process is rushed which can result in incomplete and/or inaccurate reports and misleading conclusions. Many investigators don’t have the appropriate skill sets and even those who do are not always appropriately trained. We often see little attention paid to adopting what we think would be regarded as fair procedure, and doctors can encounter an adversarial approach from investigators. In some cases it seems as if a decision has been taken from the start that a particular individual is ‘to blame’ and the investigation proceeds on that basis in order to provide ‘proof’, rather than starting with a clean sheet and an attempt to ascertain the facts before reaching any judgement. We could cite numerous other examples which equally demonstrate the main failings of the investigatory processes that we see when members are involved in an unexpected death.

However, to illustrate how we suggest the process could be improved, we attach our response to a recent consultation by NHS Improvement on the serious incident framework.

Many of the comments and observations we made about improving serious incident investigations apply equally to investigations in cases where there is an unexpected death. Our suggestions cover areas such as the need for each organisation to publicise what its investigation process is (so that anyone who has any part knows how it works and what to expect) and adhere to it; to the need to set minimum levels of resource for investigation teams and minimum levels of knowledge, skills and experience for the investigators themselves. One of the problems we see in some smaller trusts is there are only a few incidents, which is good for patients and the trust but not for investigators who need to ensure they gain enough experience to keep their knowledge and skills up to date. Our consultation response also deals with how this and other problems might be addressed.

The NHS England Quality Board has a suite of publications providing guidance to NHS trusts on learning from deaths. It recently published a new document in that series,[*Guidance for NHS trusts on working with bereaved families and carers*](https://www.england.nhs.uk/wp-content/uploads/2018/07/learning-from-deaths-working-with-families.pdf)**,** which provides guidance for trusts on how to work with families and carers with compassion and how to learn from these incidents. It is notable that while it rightly concentrates on those left behind after a close relative or friend has died, it contains little reference to the effect of a patient’s death, especially an unexpected death, on staff who were responsible for the care of the deceased patient.

There is little acknowledgment in this publication or in others in the suite, of the distressing effect such deaths can have on clinicians and especially on the need to treat the clinical team in an equally fair and compassionate way, especially if they are under scrutiny. It advises that clinicians needs to be trained and supported to help them to communicate with families and friends, which is of course important, but there is no mention that clinicians themselves may need support, or that they should be able to look to their employing trust to give them such support. It is interesting that, in contrast to this approach, the new Duty of Candour Procedure (Scotland) Regulations 2018 require (Regulation 8) trusts to provide staff with details of support available to them. This is a step in the right direction.

**Would there be benefits in ensuring a human factors assessment approach is used in local investigations as opposed to a root cause analysis? ’Human factors’ refer to the environmental, organisational and job factors, and human and individual characteristics which influence behaviour at work in a way which can affect health and safety. A ‘root cause’ analysis is a systematic process for identifying ‘root causes’ of problems or events and an approach for responding to them.**

In our response to the Williams Review we advocated mandatory human factors training for those involved in the prosecution process. We expect it could be equally beneficial in local investigations and suggest you seek the views of the Healthcare Safety Investigation Branch.

If, at the root of this question is the suggestion that it is often the clinician who was treating the patient at the time of death who is the focus of the investigation, rather than the investigation looking into other factors such as the systems and procedures in place at that time – to identify whether and what role they played in the tragedy – we agree this happens too frequently. Indeed beyond that, the effect of the errors of others and failures in a system need to be carefully evaluated in looking at their effect on the actions and thinking of an individual in order to assess the extent to which that individual’s conduct can be considered blameworthy. We believe it is a matter of good practice with patient safety incidents to investigate all factors that might have played a part in the incident, rather than concentrating just on one or more clinicians, and hope this will be borne out when HSIB publishes guidance for trusts on good practice in conducting investigations into patient safety incidents.

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

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

**In your hospital/trust/board or other healthcare setting, is there a standard process/protocol for conducting investigations following a serious clinical incident leading to a fatality? If so, please email a copy to** [**ClareMarxReview@gmc-uk.org**](mailto:ClareMarxReview@gmc-uk.org)

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

In answer to all these questions about those who are involved in conducting investigations and the standard processes and protocols that are applied, colleagues working in trusts will be in a better position to provide details from their workplace. The MDU’s experience, as we outlined above is there is wide variation throughout the UK.

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

**How are independent experts selected, instructed and their opinions used? Is access to appropriate expertise always available? Do they have training in unconscious bias?**

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

The MDU is not in the best position to speak about how individual trusts appoint clinical experts and quality assure the advice they provide. Colleagues in trusts will be better able to explain how this works for their organisation.

Our general experience is that, while some of the same clinicians are used to provide expert advice and reports for trust investigations and for other matters such as civil claims or regulators’ investigations, this is the exception. Thus, whereas a doctor who acts as an expert in civil claims is given clear guidance by the courts as to what they expect of doctors giving opinion and evidence, we see little to suggest that there are many experts used in local investigations who are instructed in the same careful and consistent way.

While doctors who act as experts in other forums may be able to bring that knowledge when they also act as an expert in trust investigations, doctors who act only occasionally in trust investigations will not have this to call upon. We don’t know how carefully these doctors are instructed and what emphasis is placed upon the need to be independent and only to opine on matters within their current expertise. We certainly see cases where there are problems with expert reports which do not withstand close scrutiny and/or challenge.

We don’t know whether this arises from unclear instructions or other reasons, but there are a number of cases where it is obvious in the opinions provided that the experts don’t understand their role in providing an independent clinical opinion. Another problem with some local experts is there is an obvious conflict of interest with the clinician under scrutiny, or they are from a completely different specialty, but that does not seem to be any bar to their providing an opinion. In summary, while we do see experts who understand their role and who provide a thorough and independent opinion, we see plenty where we need to challenge one or more aspects of the process, from the appointment of that clinician in the first place through to the timeliness in delivery, quality and accuracy of the report provided.

**How can we make sure that lessons are learned from investigations following serious clinical incidents? (please respond here if you haven’t already responded to this question in the patients and families section)**

Colleagues in trusts are better placed to respond to this question. For the MDU’s part, we are committed to helping our members to improve patient safety and regularly provide them with information about cases where something has gone wrong, with risk management advice, to help them to avoid future incidents. We can also point to the NHS Improvement National Reporting and Learning System which was set up with the express aim of learning from serious incidents, but we do not know how effective this is in terms of sharing and promoting learning.

We also have a comment about learning how to improve the investigation process itself. Some trusts have introduced a feedback procedure and at the conclusion of serious incident investigations actively seek the views and comments of participants to help them to understand what worked and what aspects of the procedure might need improvement or change. We support this type of approach and believe it is worth considering for wider use.

**What support is provided for doctors following a serious clinical incident that has resulted in the death of a patient (including emotional, educational, legal, professional support)? Could this be improved? If so, how?**

Please see our comments above about the lack of acknowledgement in NHS England’s literature about learning from deaths about the need to provide support for clinicians associated with unexpected deaths.

In the MDU’s experience, some trusts are very supportive of doctors involved in unexpected deaths, either because there is a clear trust policy or because the doctors are fortunate to have a clinical director and/ or colleagues who understand and who are supportive. Unfortunately this is not the norm and our members often report the experience as one where all those in authority in the trust seem to close ranks and thrust the doctor into the spotlight unaided and, in some cases, behaving in a hostile manner towards that doctor while doing so. For example, for all the trusts where we have seen a careful and measured press release about the incident, which does not name any individual while an investigation is ongoing, we have seen far more where individual doctors are named and the first they know of it is when the story appears in the local and/or national media.

The MDU sees its role to assist and support our members. We have a specialist in-house legal team that has over 50 years’ experience of criminal cases against doctors and they work closely with our medico-legal advisers, who are all licensed doctors, so that our members know they have someone knowledgeable and empathetic on their side whom they can contact at any time. We also have a press office that specialises in dealing with the media in such cases and that can redirect media interest away from the individual member. But in too many cases it seems our members have little or no access to any other support, formal or informal, outside the trust’s occupational health department. And, while an unexpected death and all that an investigation for GNM entails are daunting enough, it is important to remember that doctors are, unusually, subject to multiple jeopardy. They may be, and in these sorts of cases often are, also subject to a range of other procedures from employers’ and regulatory investigations to inquests, complaints, claims and, as we have observed above, very often trial by media in such cases. While they have the support of the MDU throughout, there is very little else available to them.

**How and when are decisions made to refer a fatality to the coroner, or in Scotland, to the police? Who does it? Who do you think should do it?**

In the MDU’s experience, in England and Wales most cases are referred by coroners and we have misgivings about the guidance provided to coroners about gross negligence manslaughter. We addressed these with proposals for improvement in our attached submission to the Williams Review which we were pleased to see recommended:

‘The Chief Coroner should consider revising the guidance on gross negligence manslaughter in Law Sheet no 1 in light of the explanatory statement set out by the working group under the previous recommendation in chapter 7. We expect coroners will routinely consider this guidance in assessing the facts on whether or not a referral for a criminal investigation should be made.’

**What evidence is there that some groups of doctors (by virtue of a protected characteristic) are more or less likely to be subject to investigations leading to charges of GNM/CH than other groups?**

**What are the factors that may be driving a greater likelihood for certain cohorts of doctors to be subject to investigations leading to charges of GNM/CH?**

**Do you think there are barriers or impediments for some groups of doctors to report serious incidents and raise concerns? More specifically are there additional barriers for BME (black, minority and ethnic) doctors? If so, which groups are affected by this and how can those barriers be removed?**

**This section focuses on inquiries by a coroner or procurator fiscal**

**What is your knowledge or experience of cases involving clinical fatalities that have been referred to the police or procurator fiscal?**

**What can we learn from the way those cases have been dealt with?**

We have covered both of these areas in considerable detail in our attached submission to the Williams Review.

**To what extent does an inquest or fatal accident inquiry process draw on or rely on the evidence gathered in the post incident investigation by the hospital/trust/board or other healthcare setting?**

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

**How are independent experts selected, instructed and their opinions used? Is access to appropriate expertise always available? Do they have training in unconscious bias?**

Coroners and others are better able to provide detailed answers to these questions. Our experience is that coroners on occasion rely on evidence provided to them and, as we have explained above in the section on investigations, in too many cases we believe the incident reports they receive from trusts are incomplete and/or inaccurate and/or misleading. Of course there is the potential for challenge, but it would be preferable to concentrate on improving the source of such reports.

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

We have addressed this above. In some cases experts advise the courts and other forums and are able to bring this expertise to advising trusts on serious incident investigations, but this is not always the case. Where experts don’t have this wider experience, this can present difficulties.

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

You would need to ask trusts, but our experience suggests this happens infrequently.

**This section focuses on police investigations and decisions to prosecute**

**To what extent does the criminal investigation and/or prosecution process draw on or rely on the evidence gathered in the post incident investigation by the hospital/trust/board or other healthcare setting?**

Our answer to this question is as above –trusts do provide investigation reports to the police but their quality and accuracy is variable.

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

**Are there factors which potentially hamper key decision makers in making fully informed decisions at each stage of the process, taking into account all the circumstances that the medical practitioner found themselves in at the time of the fatality, such as system pressures and other factors?**

**Do the key decision makers (the police senior investigating officers (SIOs), and/or prosecuting authorities) have the necessary support to enable them to make fully informed decisions on whether or not to charge a doctor of GNM/CH?**

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

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

**Under what circumstances would it be more appropriate to consider cases involving fatal clinical incidents within the regulatory system rather than the criminal system?**

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

**How are independent experts selected, instructed and their opinions used? Is access to appropriate expertise always available? Do they have training in unconscious bias?**

**Do the same standards and processes for experts apply with regards to evidence provided for the police or prosecuting authorities as they do for a local investigation, an inquest or fatal accident inquiry process? If not, why not? For example, is there a higher level or different type of expertise or skill set required?**

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

Our answers to all these questions are contained in our submission to the Williams Review. We would add that we do not believe that experts consulted by the police receive training in unconscious bias. The latest SIO guidance does refer to how expert reports should be constructed, with the observation ’Experts must be professionally correct, because opinions are likely to be challenged by defence experts’. The lack of reference to the Criminal Procedure Rules and/or the need for a balanced opinion, with the expert’s duty being to the court, speaks for itself.

**What lessons can we take from the system in Scotland (where law on ‘culpable homicide’ applies) about how fatal clinical incidents should be dealt with?**

We addressed this in our initial comments. While the Scottish offence is strictly different from GNM, in practice it would be likely to amount to a significantly similar threshold. However, there are few investigations and, as far as we know, there have been no prosecutions of doctors in the context of healthcare provision. This does not represent any significant difference in the Scottish legal test, but a proper understanding of just how exceptionally bad conduct has to be to establish the offence. We believe the same understanding and policy approach should apply in England and that investigation and prosecution of healthcare practitioners should be reserved for only the worst cases.

**This section focuses on the professional regulatory process**

**What is your experience of the GMC's fitness to practise processes in cases where a doctor has been convicted of a serious criminal offence?**

The GMC’s FTP process doesn’t differ in that all cases that are determined to meet the threshold are investigated in the same manner. There are some practical differences that are outside the GMC’s control, for example with timescales for GNM cases, as the GMC usually waits until there is a decision from the police or, if the case is prosecuted, until there is a court decision. The GMC may also have difficulty obtaining evidence from the police.

The main problem that we perceive is that interim orders are very frequently applied when doctors are investigated for GNM. Very often in these cases, where the investigation can last a year or more, the doctor become deskilled, not to mention the stigma attached and almost invariable loss of confidence. This is particularly frustrating in cases where the trust would have allowed the doctor to continue to work, even if in a different or non-clinical role, save for the interim order. We do not believe referral to an interim orders tribunal should be used so readily when the GMC knows that the great majority of GNM investigations are discontinued and that, ultimately there are no regulatory findings or sanctions. There is in our view an inappropriate concern on the part of the GMC and MPTS interim orders tribunals that the mere fact of a police investigation means that public confidence in the profession can only be maintained by making some form of interim order. We believe the public is more intelligent than that.

Looking at cases where doctors have been suspended as a result of their involvement in GNM investigations which then came to nought, is it not possible for regulators to identify factors that could indicate a different and more proportionate approach? The GMC has acknowledged in the last few years that most single clinical incidents are unlikely to amount to impaired fitness to practise and such cases are now generally referred to its provisional enquiry procedure. We believe it should look at GNM cases, which are invariably single clinical incidents, in a similar way. We are not suggesting they should be preliminary enquiries, but that the GMC should satisfy itself that the approach it takes to referral for interim orders of such cases is consistently proportionate and fair.

**The GMC has a statutory duty to: promote and maintain public confidence in the medical profession, and promote and maintain proper professional standards and conduct for doctors. What factors do you think the GMC should balance when trying to fulfil both these duties where there have been mistakes that are ‘truly, exceptionally bad’ or behaviour/rule violations resulting in serious harm or death?**

We are not advocating any major change to the GMC’s FTP procedure in this respect as we are able to take action on behalf of a member as the case progresses. For example, if a case proceeds to a medical practitioners tribunal and a decision is made that we believe is unfair or irrational, we can bring a judicial review on behalf of the member.

**What information would you like to see from the GMC and others about the role of reflection in medical practice and how doctors’ reflections are used?**

We understand the GMC is revising its guidance on the role of reflection in medical practice for the purposes of its own guidance and in collaboration with other organisations to produce joint guidance. We are already feeding into these processes on behalf of members.

**What emotional, pastoral and other support is available for doctors who have an allegation or charge of gross negligence manslaughter or culpable homicide and are being investigated by the GMC?**

We have addressed this above. Aside from the expert medico-legal support provided by organisations such as the MDU, there is little formal support available for doctors.

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

When identifying problems and learning lessons from unexpected deaths, it is important to do this as soon as possible after the event, while all the evidence is still fresh, and in order to ensure as soon as possible, there will be no repeats. This is best done locally and by the organisation in which the death happened. Quite often the GMC investigates a case some considerable time after the incident and it will not have the whole picture but only the part the doctor under investigation played in it. For these reasons the GMC is not the best body to identify learning at the time it is most important to do so, but it may have a role in sharing information collectively with the profession through its *SOMEP* publications.

We expect that the Healthcare Safety Investigation Branch may have an increasingly important role to play. It has as its focus learning from incidents and sharing that learning widely, for the benefit of NHS patients and staff.

**MDU contact**

**Mary-Lou Nesbitt**

[mary-lou.nesbitt@themdu.com](mailto:mary-lou.nesbitt@themdu.com)