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Document Version

Early version, also known as pre-print

Citation for published version (Harvard):

Griffiths, D & Sanders, A 2012, The road to the dock: prosecution decision-making in medical manslaughter cases. in A Sanders & D Griffiths (eds), *Bioethics, Medicine and the Criminal Law: Medicine, Crime and Society*. vol. 2, Cambridge University Press, Cambridge, pp. 117-158.

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The road to the dock: prosecution decision-making in medical manslaughter cases

Danielle Griffiths and Andrew Sanders

1. Introduction

There has been concern in the last few years in England and Wales about the imposition of criminal liability for negligently causing death in a health care context. It has been asserted that prosecution rates are increasing¹ and that the Crown Prosecution Service (CPS) is now much more willing to prosecute than it was in the past.² Concern has been heightened as research has shown that prosecutors, judges and juries all struggle with the ill defined concept of gross negligence, and there is no evidence that prosecutions have improved patient safety or accountability. Furthermore, as the test for gross negligence manslaughter is an ‘objective’ one, there need be no evidence of subjective culpability (which is often seen as synonymous with ‘moral’ culpability). Such problems have led to calls to raise the bar of liability by, for example, creating a subjective recklessness test or a more substantive test for ‘gross negligence’.³ In this paper we examine the nature of medical manslaughter

¹ O. Quick ‘Prosecuting “Gross” Medical Negligence: Manslaughter, Discretion, and the Crown Prosecution Service’ (2006) 33 *Journal of Law and Society* 421-450.

² R. Ferner and S. McDowell, ‘Doctors charged with manslaughter in the course of medical practice, 1795-2005: a literature review’ (2006) 99 *J. of the Royal Society of Medicine* 309.

³ See, for example, O. Quick ‘Medicine, Mistakes and Manslaughter: a Criminal Combination?’ (2010) 69 *Cambridge Law Journal* 186.

cases, analyse the decisions of prosecutors in these cases, and assess whether the tests for manslaughter (even if modified in the ways suggested above) are workable in the medical context.⁴ First we need to understand how these cases arise in the first place.

Criminal investigations into medical deaths have three main sources: relatives making complaints to the police directly, a hospital contacting the police, or a coroner becoming concerned that there is something unnatural or suspicious about a death and referring it to CID. Analysis of inquest files over a ten-year period from three Coroner's Offices shows a threefold increase in complaints to coroners and the police from relatives of deceased people about standards of medical treatment. The files also show that coroners and the police respond to, and pursue investigations into, medical deaths more frequently than they used to. Even if there is no subsequent criminal charge, police investigations and inquests into medical deaths are now also much more likely to be held than they were ten or more years ago. Inquests into medical deaths in 2004-2008 were almost double the number in 1999-2003.⁵

⁴ Research for this article has been developed as part of an Arts and Humanities Research Council (AHRC) funded project entitled 'The Impact of the Criminal Process on Health Care Ethics and Practice', based at the Universities of Manchester, Lancaster and Birmingham. The support of the AHRC is gratefully acknowledged. See <http://www.law.manchester.ac.uk/research/hccriminalprocess/index.html>. We also thank the CPS, and in particular prosecutors based in Special Crime and Counter Terrorism Division (SCCTD), formerly the Special crime Division (SCD), for the help they gave us in providing access to files and facilities, and who gave considerable time talking with us, commenting on this paper and joining our discussions. The paper would not exist without the help of the CPS – the informal help as much as the formal access. Nothing in this paper is, however, necessarily endorsed by CPS.

⁵ Analysis of the early decision making process in cases of medical error was conducted as part of the AHRC research and examined the factors influencing the attrition of a case as it proceeded through the

Once the police have begun an investigation they either refer the case to the CPS for advice or investigate fully and then refer the case to the CPS. The CPS was established in 1986 under the Prosecution of Offences Act 2005. Under the Act, investigation and prosecution were split, with the former being the duty of the police and the latter the CPS in order to try to achieve improved consistency and accountability, but the decision whether or not to prosecute was left with the police. The Criminal Justice Act 2003 transferred this decision to the CPS in virtually all cases. However, if, after some investigation, the police decide there is insufficient evidence to prosecute, they need not refer the case to the CPS in most cases.⁶

Decisions whether to prosecute are guided by the Code for Crown Prosecutors which sets out a two stage test. The first is whether there is sufficient evidence (defined as a realistic prospect for conviction). The second is whether prosecution is in the public interest. The Code specifies that the more serious the offence the more likely it is that it will be in the public interest to prosecute. So, where homicide is concerned, only in cases where there are exceptionally extenuating circumstances (assisted dying provides most of the examples)⁷ will it be decided that the public interest requires no prosecution. In this paper we look only at the evidential stage as we found no cases where the CPS believed there was sufficient evidence yet explicitly exercised their discretion, on public interest grounds, not to prosecute. Whether they

criminal process. See D. Griffiths 'Medical Manslaughter and the Decision Making Process: Discretion and Attrition' (unpublished).

⁶ Discussed more fully in A. Sanders (this volume) and A. Sanders, R. Young and M. Burton, *Criminal Justice* (Oxford: OUP, 2010) Ch. 7.

⁷ For discussion see A. Mullock, 'Overlooking the Criminally Compassionate' (2010) 18 Med LR 442; R. Bennett and S. Ost (ed.) (CUP 2012); A. Sanders (this volume).

ever implicitly did do will be considered in section 4, for as we show in section 2 below, discretion can often be disguised as ‘judgement’ about evidential sufficiency.

The Special Crime Division (SCD) of the CPS was established in 2005 (and became SCCTD in April 2011) to handle the most sensitive and complex cases across the country, and to provide advice to investigating bodies such as the police and Health and Safety Executive and to other prosecutors within local CPS offices. As ‘medical manslaughter’ is such a specialised area of crime, SCD is expected to take a more active role in guiding these investigations than in most other criminal cases. Thus the CPS asks the police to consult SCD well before the question of any criminal charge for medical manslaughter (MM) arises.⁸ This is to ensure that a) the case warrants further investigation; and b) (if it does) lines of enquiry are directed to establishing whether or not there is evidence in relation to the elements of MM (discussed below). Ideally, advice will be given at an early stage on the legal tests that need to be met and the appropriate experts from whom to seek expert reports. Whether the police follow this advice is up to the police themselves and it seems that the police did not always follow up lines of enquiry suggested by CPS in cases that were not pursued (see section 4 (a)). The greater problem was that sometimes the police carried out full investigations before consulting the CPS, and thereby inadvertently set some cases on lengthy paths that could not lead to successful prosecutions, even though this might not have been the result had they been properly advised at an earlier stage. For example, we came across a case where inappropriate experts were instructed by the police and the case was closed due to the experts’ advice that the breach in question would not reach the gross threshold. At the

⁸ No specific protocol exists which instructs the police to refer a case to the SCCTD although it is currently in development by the Association of Chief Police Officers (ACPO) and the CPS.

subsequent Inquest, a coroner challenged the decision not to prosecute on the basis that other more appropriate experts would probably have come to different decision, however this was eight years after the incident occurred when vital evidence had been destroyed and key witnesses had died. Once the investigation is complete a member of SCD decides whether or not to prosecute (and, if so, who to prosecute) and compiles a detailed ‘review note’ which explains that decision in detail.

A related background issue concerns the ‘right to life’ under Article 2 of the European Convention on Human Rights (ECHR). The Human Rights Act 1998 in effect incorporated the ECHR into English law. Article 2 has been interpreted to mean that public bodies (such as the police and CPS) are obliged to conduct investigations that are as full as practical in order to establish who may have been responsible for any deaths.⁹ Part of the rationale for SCD is that it deals with the difficult ‘right to life’ cases (that is, including deaths in custody, assisted suicide, corporate manslaughter).

Because of the Article 2 obligations, the police and CPS feel obliged to investigate more such cases, including ‘medical manslaughter’, than they might otherwise do: given that, as in all organisations, there is no infinite supply of resources, the police and CPS would normally decide whether particular cases should be allocated resources on the basis of a combination of factors such as seriousness and probability of securing sufficient evidence to prosecute. Article 2 also makes it difficult to adopt a nuanced approach to the depth of investigation: a full investigation is required unless and until it is clear that there is insufficient evidence. We shall see that this means that many cases are investigated for more extensively than would

⁹ *Avsar v. Turkey* (2001) 37 EHRR 1014; *Ramsahai* [2008] 46 EHRR 43. For a recent example see *R (on the application of JL) v. Home Secretary* [2009] 1 AC 588.

seem to be warranted, as the probability of securing sufficient evidence will vary from case to case. An SCD prosecutor told us that when she had previously worked on sexual assault cases she was given far less time for those cases than she had for SCD cases that were usually going nowhere. Doubtless this accounts for at least some of the increase in medical-death investigations, their duration, and the number of suspects in them, creating more of a shadow over health care professionals (HCPs) than there would otherwise be. In taking up so many resources, even less is then available for other cases, even serious ones such as sexual assault. The problem is compounded by many police investigators failing to consult SCD at an early stage. Early consultation allows SCD to advise on what lines of enquiry are needed, allowing some investigations to be cut short when it becomes apparent that there is no possibility of prosecuting anyone.

The way Article 2 has been interpreted also means that many coronial investigations are more extensive than they would otherwise be. Since the police prepare many full files for this purpose, they submit these files to the CPS for prosecution decisions. Much of the content is not needed for such decisions, but as it has been gathered anyway it provides useful background information for the CPS reviewer.

2. The uncertainty of gross negligence manslaughter and medical manslaughter

Homicide law in England and Wales forms a ladder of offences of descending severity:

- 1) Murder: causing death with the intention of doing so or of causing GBH

2) Manslaughter

- a) Voluntary: where the charge would be murder were it not for a partial defence (e.g. diminished responsibility due to a cognitive problem on the part of the defendant); or
- b) Constructive: causing death by doing an act (or, perhaps, omission) that is criminal and that requires intention or recklessness and which is liable to cause some harm (though not necessarily serious harm); or
- c) Gross negligence: causing death by breaching a duty of care to the deceased; this breach must be an act (or omission) that is grossly negligent, and death must be reasonably foreseeable; or
- d) Reckless: although there have been no reported cases charged as such for many years, as it is difficult to think of a circumstance where recklessly caused death will not fall into one of the other categories of manslaughter, there is general agreement that this category does exist in theory.¹⁰ Indeed, many cases charged as murder but where a plea to manslaughter is accepted or where the jury only convicts of manslaughter probably come into this category.¹¹ The idea is picked up by Quick, as we shall see in section 5.

- 3) Lesser homicide offences such as death by dangerous driving (RTA 1988, section 1) and death by careless driving when intoxicated (RTA 1988, section

¹⁰ See e.g. Law Commission, *Involuntary Manslaughter* (Report No. 237, 1996) para. 2.26; Clarkson, Keating and Cunningham, *Criminal Law: Cases and Materials* (London: Sweet & Maxwell, 2010), p. 644; J. Herring, *Criminal Law Cases and Materials* (Oxford: OUP, 2010), p. 277.

¹¹ C. Clarkson, 'Context and culpability in involuntary manslaughter', in A. Ashworth and B. Mitchell eds., *Rethinking English Homicide Law* (Oxford: OUP, 2000).

3A as amended by RTA 1991).

There is also corporate homicide under the Corporate Manslaughter and Corporate Homicide Act 2007, which does not fit into this hierarchical ladder as it covers a potentially very wide range of homicides.¹²

‘Medical manslaughter’ (MM) is not a technical term, but is a form of gross negligence manslaughter (GNM: 2) (c) above). MM refers to medically qualified individuals who are performing acts within the terms of their duty of care, when an act or omission allegedly causing death occurs.

The leading cases on GNM are *Adomako*¹³ and *Misra*¹⁴ which, by coincidence, are both MM cases. Several elements need to be proven for GNM:

- a) the existence of a duty of care to the deceased;
- b) a breach of that duty of care which;
- c) causes (or significantly contributes) to the death of the victim; and
- d) ‘whether the extent to which the defendant’s misconduct departed from the proper standard of care ... involving as it must have done, a risk of death to the patient, was such that it should be judged criminal ...’ (the ‘gross negligence’ element).¹⁵

¹² For discussion see Wells (this volume).

¹³ [1995] 1 AC 171.

¹⁴ [2005] 1 Cr App R 21

¹⁵ *R v. Adomako* [1995] 1 AC 171 at 187.

Establishing the existence of a duty is rarely problematic in MM cases. In most MM cases it is also evident whether a duty was breached (unlike in many other GNM situations, such as where drugs are supplied to a friend).¹⁶ Although we shall see that around thirty percent of MM non-prosecutions are because no breach could be established, in only half of these (i.e. fifteen percent of the total) is this because no breach can be established at all; in the other half it is not clear who breached their duty (see section 4 (c) below). However, we shall see in section 4 that the other elements often are problematic. Causation is a particular problem in MM cases. And ‘gross negligence’ is an intrinsically elusive concept that is problematic in all types of GNM case: in *Adomako* Lord MacKay said that whether a breach of duty

... should be characterised as gross negligence and therefore as a crime ... will depend on the seriousness of the breach of duty committed by the defendant in all the circumstances in which the defendant was placed... The essence of the matter which is supremely a jury question is whether, having respect to the risk of death involved, the conduct of the defendant was so bad in all the circumstances as to amount in their judgment to a criminal act or omission.¹⁷

This is as close to a definition of ‘gross negligence’ as we have. Brazier and Allen note that

¹⁶ See e.g. C. Clarkson and S. Cunningham (eds.), *Criminal Liability for Non-Aggressive Death* (Aldershot: Ashgate, 2008) (Chapter by Wilson).

¹⁷ *R v. Adomako* [1995] 1 AC 171 at 187.

In practice, it seems that the offence of gross negligence manslaughter, as it stands, involves circularity; juries being told in effect to convict of a crime if they think a crime has been committed.¹⁸

Circularity was a frequent criticism of the *Bateman* test of gross negligence,¹⁹ on which the test in *Adomako* is based. A type of homicide that has been criticised so frequently and so consistently yet which was affirmed – largely unchanged – seventy years after first being formulated seems curiously indispensable.

The test for gross negligence manslaughter is objective. Disregard and recklessness are not required for conviction. Cases involving a momentary (but major) error with no evidence of recklessness or disregard, such as miscalculating the dose of diamorphine, have therefore resulted in conviction.²⁰ Thus caring doctors who do their best for patients but who make a terrible mistake have found themselves cast into the criminal process. Dr Sullman and Dr Prentice were junior doctors who had their case heard in the House of Lords at the same time as *Adomako*. They made the error of injecting vincristine into the spine of their patient, having been put in the position

¹⁸ M. Brazier and N. Allen, 'Criminalising Medical Malpractice' in C. Erin and S. Ost, *The Criminal Justice System and Health Care* (Oxford: Oxford University Press, 2007), p. 21. This is a common criticism. See e.g. Law Commission, *Involuntary Manslaughter*, para. 3.9; discussion in J. Herring, *Criminal Law Cases and Materials* (Oxford: OUP, 2010), pp. 291-8.

¹⁹ *R v. Bateman* (1925) Cr App R 8. See criticism by, for example, G. Williams, *Textbook of Criminal Law* (London: Stevens, 1983); successive editions of J. Smith and B. Hogan, *Criminal Law* (Oxford: OUP).

²⁰ E.g. *R v. Becker* (2000) WL 877688.

of administering such treatment untrained and unsupervised. The error was fatal, and the sixteen year old patient died some days later in agony. It is true that the judge at their trial expressly told them that they were not ‘bad men’.²¹ And indeed Dr Sullman and Dr Prentice had their convictions quashed by the Court of Appeal. Now it has been suggested in *Rowley* that

It is clear from what Lord Mackay said [in *Adomako*] that there is a fifth ingredient: criminality ... or ‘badness’. Using the word ‘badness’, the jury must be sure that the defendant’s conduct was so bad in all the circumstances to amount ‘to a criminal act or omission’.²²

However, it would be wrong to conclude that the *defendant* must be ‘bad’ – i.e. subjectively culpable – in order to satisfy this test. Whilst a defendant’s recklessness may be one of the ‘circumstances’ that forms part of the evidence that negligence was ‘gross’, subjective recklessness is not a requirement. Thus as far as ‘the law’ is concerned (in the strict black-letter sense) it is hard to see how this really is an additional test. Indeed, neither the Law Commission²³ nor the standard textbooks that we scrutinised for this purpose²⁴ mention *Rowley* which is, after all, a rather obscure challenge to a decision not to prosecute for MM. And in no other discussions of GNM

²¹ *R v. Prentice; R v. Sullman* [1994] QB 302.

²² *Rowley v. DPP* (2003) EWHC Admin 693 per Kennedy LJ.

²³ Law Commission, *Involuntary Manslaughter*, para. 2.10.

²⁴ E.g. A. Ashworth, *Principles of Criminal Law* (Oxford: OUP, 2009); J. Herring, *Criminal Law Cases and Materials* (Oxford: OUP, 2010).

have we seen mention of a ‘fifth test’.²⁵ In *Misra*, the leading MM case since *Adomako*,

The jury concluded that the conduct of each appellant in the course of performing his professional obligations to his patient was ‘truly exceptionally bad’, and showed a high degree of indifference to an obvious and serious risk to the patient’s life. Accordingly, along with the other ingredients of the offence, gross negligence too, was proved.²⁶

There are three points to note here: first, it is the conduct, not the defendant or his/her mental state, that must be ‘truly exceptionally bad’; second, this ‘badness’ seems to be relevant to the Court of Appeal in respect of proof of gross negligence and ‘the other ingredients of the offence’ not as a ‘5th test’; third, no ‘5th test’ was mentioned in the judgement. And to take a more recent case at random, in *Evans*²⁷ the four *Adomako* tests were put to the jury and this was endorsed by the Court of Appeal.

Prosecutors in SCD drew *Rowley*’s ‘fifth test’ to our attention because they rely on it heavily, it being drawn to their attention by the DPP’s *Legal Guidance* to

²⁵ Quick alone refers to *Rowley*. He draws attention to the endorsement in that case and in *Misra* of the use of evidence of subjective recklessness by Lord Mackay in *Adomako* (though this is not required). But he does not identify any ‘5th test’. See O. Quick, ‘Medical manslaughter: The rise (and replacement) of a contested crime?’ in C Erin and S Ost, *The Criminal Justice System and Health Care* (Oxford: Oxford University Press, 2007).

²⁶ *R v. Misra* [2005] 1 Cr App R 21 at para. 66, per Judge LJ

²⁷ *R v. Evans* [2009] 2 Cr App R 10. Also see *R v. Connolly* [2007] 2 Cr App R (S) 82, where *Misra* and the *Adomako* tests were discussed and applied but no ‘5th test’ was mentioned.

Crown Prosecutors on homicide.²⁸ Prosecutors also rely heavily on the obligation to consider ‘all the circumstances’ highlighted in the judgements in *Rowley* and in *Misra*. But this is a meaningless obligation. Presumably prosecutors, judges and juries are not being asked to consider irrelevant circumstances. But, logically, no-one should need to be told to consider all *relevant* circumstances, for to fail to do so would by definition be failing to make a full consideration. The result of the ‘5th test’ and of being asked to do something that need not be stated is that prosecutors seem, as we shall see in section 4, to strain for something over and above objective gross negligence. What, in another context, might seem to be evidence of recklessness can be regarded as ‘bad’ and a relevant ‘circumstance’ justifying the view that there is sufficient evidence of gross negligence to justify prosecution; while what, in another context, might seem to be a mitigating factor comes to be seen as a ‘circumstance’ that makes the action less ‘bad’ and thus justifying the view that there is insufficient evidence of gross negligence to justify prosecution.

Despite the objective nature of the gross negligence test, in many reported cases the doctors who are prosecuted did seem to act recklessly: for example, the two doctors who, over a period of two days, ignored warnings and failed to act on evidence that their patient was critically ill.²⁹ And in section 4 we shall see that this was true of all the (admittedly few) prosecuted cases in our sample. The ‘fifth ingredient’, if it really should be characterised as such, of ‘badness’ does therefore seem to exercise some power in reality, particularly when coupled with the obligation

²⁸ Prosecutors in SCD strongly suggested to us that ‘badness’ in a general sense – that we found difficult to understand as other than subjective recklessness – is needed.

www.cps.gov.uk/legal/h_to_k/homicide_murder_and_manslaughter/index.html.

²⁹ *R v. Misra* [2005] 1 Cr App R 21

to consider ‘all the circumstances’: to emphasise the grossness required of the negligence, such that a momentary slip would have to be something the absolutely overwhelming majority of defendants would never do if they had the training, and were in the circumstances, of the defendant; and to sensitise prosecutors to what they perceive to be a requirement of more broadly-defined ‘badness’ than was evident from the judgement in *Adomako*.

A classic example is the case of two patients who died as a result of being given a cancer drug that was five hundred percent too concentrated. This happened because a) the prescribing doctor, Dr Tawana, did not specify the brand of the drug, a crucial error since different brands came in different concentrations; and b) the nurses administering the drug did not heed the warning on the drug containers to check that the dosage was appropriate. On the face of it this was gross negligence on the part of all three because the drug was known to be highly toxic in large quantities, and so they would or should have known that there was a risk of death if a mistake of this kind was made. The police investigated and consulted CPS over a MM prosecution, but CPS declined to prosecute, despite this clearly being no momentary slip.³⁰

The vagueness of the ‘gross negligence’ and ‘badness’ tests (such as they are) leads a substantial reliance on the judgement and opinion – or as some prosecutors told Quick, ‘gut instinct’³¹ – of the prosecutor and the specialists (usually doctors) instructed to be expert witnesses.³² Thus prosecutors who wish to prosecute only

³⁰ Birmingham Post Late, 13 July 2010.

³¹ Quick ‘Prosecuting “Gross” Medical Negligence’, 440.

³² O. Quick ‘Expert Evidence and Medical Manslaughter: Vagueness in Action’ (2011) 38 *Journal of Law and Society* 496.

where they find subjective recklessness are able to do follow their preference.³³

Quick found that prosecutors and expert witnesses struggle to define their understanding of ‘gross’ and that the ‘prosecution recipe’ for gross negligence manslaughter is still kept secret. The results are gross uncertainty for health care professionals,³⁴ potential inconsistency; and, we shall argue, discretion based on ‘public interest’ considerations (such as blameworthiness) but hidden under the guise of a determination that the negligence was insufficiently gross. Before looking at our data in detail there are three general criticisms of GNM in general (and MM in particular) that we need to tackle.

a) Moral luck

Medical negligence only becomes a crime if the patient dies.³⁵ So a health care professional can make the most horrific error and yet escape criminal liability if the patient survives the mishap (as in the Jamie Merrett case discussed in section 5). Indeed, it is likely that only a minority of life-risking negligent error actually leads to death. Luck plays a large part in relation to causation too: no matter how grossly negligent an act may be, if the perpetrator is lucky enough to find that an intervening cause breaks the chain of causation, there will be no criminal liability. We shall see that in many MM cases death could have been caused by many factors, frequently

³³ See O. Quick, ‘Medical Manslaughter: The Rise (and Replacement) of a Contested Crime’.

³⁴ See O. Quick (2007) *op cit*. Although, as will already be evident, in reality there are prosecutions only in the worst cases.

³⁵ See M. Brazier and A. Alghrani ‘Fatal medical malpractice and criminal liability’ (2009)

making it impossible to determine whether the suspect was the, or even a substantial, ‘cause’ of death. Unlike other forms of homicide, in most cases of GNM there is no ‘lesser included’ offence.³⁶ We shall see in section 4 that this is quite a common problem. This means that people who are prosecutable for GNM are very unlucky. It is often said that it is therefore unfair to prosecute them. However, rather than taking away the possibility of successful prosecution in such cases, would it not be more rational to create the legal conditions to successfully prosecute those who endanger life and/or cause great suffering but cannot be proven to have ended life, if these defendants are culpable. We discuss a possible crime of negligently causing injury or negligent endangerment in section 5. But the crucial question is ‘if these defendants are culpable’.

b) Is negligence culpable?

For decades there has been a wide-ranging debate about the place of negligence (as against subjective recklessness or intent) in criminal liability in general.³⁷ The classic view is that *mala in se* (that is, real crimes) require subjective knowledge or intent, and that negligence should be the basis of liability only for *mala prohibita* (regulatory offences, behaviours that are not intrinsically bad). Thus negligence is, according to this argument, an unsuitable basis for liability for serious crimes such as manslaughter

³⁶ ‘Unlawful act’ manslaughter has the unlawful act (usually a form of assault) as a lesser included offence; ‘death by dangerous driving’ has dangerous driving as a lesser included offence.

³⁷ For example, H. Hart, *Punishment and Responsibility* (Oxford: Clarendon, 1968) and the recent critique by L. Alexander, K. Ferzan, S. Morse, *Crime and Culpability: A Theory of Criminal Law* (Cambridge: CUP, 2009).

that are on a par with other serious offences against the person that are clearly *mala in se*. However, the *mala in se/mala prohibita* distinction is a way of thinking, not a fundamental element of civilised law, or even of English law.³⁸ Even if we accept that this way of thinking does underlie English law, there is no consensus on what constitutes ‘subjective fault’: Duff, for example, argues that indifference towards a foreseeable outcome – which is effectively what is at issue in many MM cases – is a subjective fault.³⁹ There is also no consensus on many specifics e.g. what is, and is not ‘intrinsically’ bad. Marital rape, for example, was only criminalised in 1992,⁴⁰ so this was a clearly contested category twenty to thirty years ago. And many regulatory offences such as pollution, tax evasion and causing injuries through unsafe work conditions are increasingly regarded as worse than many ‘real’ crimes such as theft.⁴¹ So if negligence is an acceptable basis for liability for these crimes, why not for manslaughter?

One answer is that if these are indeed serious crimes, negligence should not be the basis of liability, for negligence is simply not a culpable state of mind.⁴² The argument is that one cannot be blamed for that which one did not know or intend. This argument may be valid for momentary carelessness, whether by act or omission.

³⁸ J. Horder, ‘Homicide Reform and the Changing character of Legal Thought’ in Clarkson and Cunningham, *Criminal Liability for Non-Aggressive Death* dubs this a ‘common law’ (as distinct to ‘regulatory’) way of thinking.

³⁹ R Duff, *Intention, Agency and Criminal Liability* (Oxford: Blackwell, 1990)

⁴⁰ *R v. R* [1992] 1 A.C. 599

⁴¹ The *mala in se/mala prohibita* distinction is attacked in, for example, A. Sanders, ‘The nature and purposes of criminal justice: the ‘freedom’ approach’ in T. Seddon and G. Smith (eds.) *Regulation and Criminal Justice* (Cambridge, CUP 2010).

⁴² Alexander, Ferzan and Morse, *Crime and Culpability: A Theory of Criminal Law*.

But greater or more sustained negligence – for things that one ought to know because, for example, one is engaging in particularly risky behaviour – is a different matter.

Take doctors or nurses who are unduly fatigued, perhaps because of unwarranted demands put on them by NHS cuts and hospital management. As Clarkson points out, choosing to treat patients in these circumstances is a knowing choice even if fatal errors causing death were unforeseen.⁴³ Or, where error is a known risk (such as the maladministration of drugs), systems are needed to guard against it.⁴⁴ Culpability often lies in the prior failures, not the error itself. The key here is the use of phrases like ‘great’, ‘sustained’ and ‘particularly risky’. Only where such phrases apply can we consider negligence to be *gross*. To adapt one of Horder’s arguments, when one deliberately adopts a course of action that creates a risk ‘I make my own luck’ in the sense that one decides how to guard against the risk created.⁴⁵ This is particularly apposite in the medical context.

An examination of the objections to GNM in general, and to MM in particular, shows that even the most informed commentators often fail to appreciate these subtleties. Merry and McCall Smith dichotomise the problem into ‘errors’ which they argue are not morally culpable; and violations which – because they are deliberate – are culpable.⁴⁶ Montgomery uses this crude objective/subjective dichotomy to similarly argue that MM has gone too far, or should even be abolished, as ‘justice does not require the use of the criminal law in the case of medical mistakes, but only

⁴³ Clarkson ‘Context and culpability in involuntary manslaughter’.

⁴⁴ A. Leopold, ‘A case for criminal negligence’ (2010) *Law and Philosophy* 455.

⁴⁵ J. Horder, ‘A critique of the correspondence principle in criminal law’ (1995) *Crim LR* 759 at 764; and see Clarkson and Cunningham *Criminal Liability for Non-Aggressive Death*, p. 5.

⁴⁶ A. Merry and A. McCall Smith, *Errors, Medicine, and the Law* (Cambridge: CUP 2001).

where professionals set out to do wrong.’ This is because: ‘Criminalisation is not appropriate for those who try to do the right thing, but fail, only for those who set out to disregard the value of life that is protected by the criminal law.’⁴⁷ But how should the anaesthetist in *Adomako* be characterised, where an oxygen tube was dislodged for 4 minutes before he noticed? No-one accused him of ‘setting out to do wrong’ but he nonetheless could be said to have ‘disregarded the value of life’. It is true that he was unduly fatigued, but this was not even a case of undue demands by the ruthless NHS as it appears that his lack of sleep was due to working at two different hospitals. Similarly what should we say about those who ‘cared’ for Lisa Sharpe by letting a drip run dry and not performing a blood test for a week despite blood samples having been taken due to persistent vomiting?⁴⁸

Tadros, on the other hand, does appear to accept Duff’s gloss on the objective/subjective dichotomy, insofar as he distinguishes between ‘lack of ability’ and ‘lack of care’. He criticises GNM because, he argues, it penalises both.⁴⁹ However, we know of no modern cases where this is so. Surely *Adomako* (the case he cites to support his argument) is a case of ‘lack of care’ rather than ‘lack of ability’. And even if ‘lack of ability’ or momentary slips were criminalised at one time, it is no longer the case in the wake of *Misra*.

⁴⁷ J. Montgomery, ‘Medicalising crime – Criminalising health? The role of law’ in Erin and Ost, *The Criminal Justice System and Health Care*.

⁴⁸ See Mencap, *Death by indifference* (www.mencap.org.uk) and *Guardian*, 3 January 2012.

⁴⁹ V. Tadros, ‘The limits of manslaughter’ in Clarkson and Cunningham, *Criminal Liability for Non-Aggressive Death*. Quick also understands the complexities of the argument but, like Tadros, believes that cases at the lower end of the culpability spectrum are being prosecuted (see section 3): See O. Quick, ‘Medical manslaughter: The rise (and replacement) of a contested crime?’.

There is therefore no clear basis on which to object to criminal liability for failure to guard against foreseeable risks of great magnitude or probability, or for gross carelessness for a sustained length of time. So, while it may be that simple negligence is not culpable and should not be the basis of criminal liability (we take no position on this), gross negligence is another matter entirely. The objection rests on a ‘distinction between “purposeful” and “chance” outcomes [that] is not always helpful in determining responsibility.’ Keating reached this conclusion sixteen years ago,⁵⁰ and if more heed had been taken of it, the debate would be far further advanced.

c) Can negligent behaviour be deterred?

Culpability is the main concern of retributivists.⁵¹ They seek to criminalise that which deserves punishment regardless of the effect of that process. Most academics and policy-makers are, however, also concerned with ‘forward-looking’ justifications for criminalising and punishing behaviour; in other words, the prevention of misconduct is a major concern. This is another ground of attack by opponents of negligence-based liability. Is it possible to deter people from failing to consider that which they should have considered? Merry argues that medical errors not done with subjective intent cannot generally be prevented through rational reflection, except in the worst cases. Hence the threat of criminal prosecution is seen as ineffectual.⁵²

⁵⁰ H. Keating, ‘The Law Commission Report on Involuntary Manslaughter: The restoration of a serious crime’ (1996) *Crim LR* 535, at 540.

⁵¹ Such as Alexander, Ferzan and Morse, *Crime and Culpability: A Theory of Criminal Law*.

⁵² A. Merry, ‘When are errors a crime? Lessons from New Zealand’ in Erin and Ost, *The Criminal Justice System and Health Care*.

However, doubt was cast on this view by Hart in 1968 and many others since.⁵³ As any parent knows, much of what we say to our children falls on deaf ears. But do we really believe that our frequent demand that they ‘Be more careful’ is both philosophically incoherent and always ineffectual? We can all learn to be more careful, and hopefully medical practitioners learn this lesson better than most. If the threat of prosecution helps us to learn, it will not be ineffective. And it is vital to remember that, as stressed above, the threshold for liability is *gross* negligence, not simple negligence. It is only the ‘worst’ cases that come into the frame.

Notwithstanding this, many cases deemed not to be ‘gross’ like that of Dr Tawana (above) are also clearly deterable: it is a classic example of where if the warning ‘be more careful’ had been heeded, lives would not have been lost. The reason why Merry’s view differs so markedly from ours is that he subscribes to the objective/subjective dichotomy discussed above. As he observes, we all make errors sometimes, so error cannot be regarded as culpable or deterable. This might make sense if the only alternative to accidental ‘error’ is deliberate ‘violation’, but as we have seen, the reality is more complex than this.

More generally, Ashworth notes that the deterrent efficacy of prosecution in general is often over-estimated and this is particularly so in medical error cases where there is no deliberate wrong-doing and most professionals will have many reasons for trying to be careful.⁵⁴ So far there is little evidence to suggest that previous prosecutions for medical manslaughter have improved patient safety or the systems failures which lead to fatal errors. For instance, despite the highly publicised

⁵³ H. Hart, *Punishment and Responsibility*. There are many later critiques e.g. Duff, *Intention, Agency and Criminal Liability*.

⁵⁴ Ashworth A, *Is the Criminal law a lost cause?* (2000) 116 *Law Quarterly Review* 1-19 at 14.

case of Drs Prentice and Sullman, the fatal mistake of accidentally administering vincristine into a patient's spine arose again in 2001 resulting in the death of an eighteen-year old outpatient, Wayne Jowett, who had been in remission from leukemia. It was reported to be the thirty-sixth incident of a fatal injection of vincristine worldwide.⁵⁵

We should not make the mistake of assuming that the only reasons for criminalisation are retribution and deterrence. Forward-looking justifications can aim at reducing crime by other means. Restorative justice (RJ) is one that is used for minor crime, and juvenile offenders in particular, but rarely for more serious crime. We briefly examine this in section 5.

There may be other reasons for a small deterrent effect. First, those doctors who are convicted very rarely go to gaol. Indeed, some return to practise.⁵⁶ However, the criminal law is used far more frequently in medical cases in France than in the UK, and a fine and/or a suspended prison sentence is regarded as sufficient: the ultimate punishment is seen to lie in just the stigma of a criminal conviction itself.⁵⁷ The second, and more plausible, reason for the minimal deterrent effect of the criminal law is a very low prosecution and conviction rate (due in part because the punitive nature of our criminal justice is widely thought to be inappropriate for MM).⁵⁸ There is no point even considering the deterrent effect of sentencing if one is

⁵⁵ M Brazier and N Allen 'Criminalising Medical Malpractice', p. 23.

⁵⁶ E.g. Dr Misra. See D. Rose, 'Doctor who killed is free to work', *The Times*, 30 November 2007.

⁵⁷ J.R. Spencer and M.A. Brajeux, 'Criminal liability for negligence – a lesson from across the Channel?' (2010) 59 *International and Comparative Law Quarterly* 7, 23.

⁵⁸ In other words RJ might lead to both more reduction in offending and more criminal action being taken. See section 5 and Sanders (this volume).

unlikely to ever reach the sentencing stage. However, the assertion that prosecutions are rare is controversial, and it is to this issue that we now turn. Meanwhile, by way of conclusion to the debate over negligence liability for homicide, as even many of those who object to GNM acknowledge, this has to be regarded as an ongoing debate, not a closed issue.⁵⁹

3. Trends in prosecutions for medical manslaughter by gross negligence

Ferner and McDowell argue that doctors have been more likely to be prosecuted for medical error since 1990 than previously.⁶⁰ They base this conclusion on media reports that identified just seven prosecutions against doctors for gross negligence manslaughter between 1945 and 1990, compared with thirty-eight between 1995 and 2005. Even when prosecutions were more frequent in the more distant past (e.g. 1835-1890 and 1925-1935) they discovered fewer than one prosecution each year on average.

This apparent increase in prosecutions needs to be situated within wider debates about a decline in public trust in professions in general.⁶¹ There is, in particular, an increasing awareness of the limits of the once hallowed health care

⁵⁹ Quick (2007) op cit.

⁶⁰ See Ferner and McDowell, 'Doctors charged with manslaughter'.

⁶¹ A. Giddens, *Modernity and Self-Identity: Self and Society in the Late Modern Age* (Polity Press: Cambridge, 1991). See also O. O'Neil, *A Question of Trust: 2002 BBC Reith Lectures* (Cambridge: CUP, 2002).

profession, and revelations that mistakes and incompetence are all too common.⁶²

Stories of patient safety scandals⁶³ and incompetent doctors⁶⁴ have proliferated in the past ten years. Andrew Ashworth notes that:

...the contours of English criminal law are ‘historically contingent’—not the product of any principled inquiry or consistent application of certain criteria, but largely dependent on the fortunes of successive governments, on campaigns in the mass media, on the activities of various pressure groups and so forth.⁶⁵

Debates about the perceived increase in medical manslaughter prosecutions have indeed linked the wider culture of distrust to an increased propensity for criminal justice agencies, particularly the CPS, to lower their evidential threshold in these cases and proceed with a prosecution, in order to serve political purposes and show that

⁶² C. Seale, ‘Health and media: an overview’ (2003) 25 *Sociology of Health & Illness* 513-531. See also A. Nathoo, *Hearts Exposed: Transplants and the Media in 1960s Britain* (Basingstoke: Palgrave Macmillan, 2009) and D. Lupton ‘Doctors in the news media: lay and medical audiences’ responses’ (1998) 34 *Journal of Sociology* 35-48.

⁶³ <http://www.guardian.co.uk/society/2009/nov/29/nhs-hospitals-safety-report>;
<http://www.bbc.co.uk/news/uk-england-stoke-staffordshire-11218638>.

⁶⁴ <http://news.bbc.co.uk/1/hi/england/hampshire/7113571.stm>;
<http://www.yorkshirepost.co.uk/news/39Incompetent39-foreign-doctor-guilty-of.6045977.jp>.

⁶⁵ A. Ashworth, ‘Is the Criminal law a lost cause?’

‘justice has been done’. Frequently concern for the victim is invoked to justify prosecutions that might not otherwise have taken place.⁶⁶ And according to Quick:

This increase of prosecutions has occurred within the broader context of rising complaints against health care professionals and the accompanying media attention to the costs of medical mistakes. Prosecutors work within this climate of increased suspicion of professionals which is likely to impact on the ‘frames’ they adopt in exercising their discretion.⁶⁷

Commenting on the low conviction rate in medical manslaughter cases, Ferner and McDowell concluded that the CPS charges too many cases and asserts that this is because it is ‘an emotionally satisfying way to exact retribution’ rather than a concern to protect patients.⁶⁸

Prosecutors argue that their decisions are based on the law and on the interpretations of/elaborations on the law set out in documents such as the *Code for Crown Prosecutors* and not because of emotion or political pressure. And, as we have seen, even the discretion to not prosecute on ‘public interest’ grounds that they do allow themselves in most cases is eschewed in most homicide cases. But we have also

⁶⁶ D. Garland, *The Culture of Control* (OUP: Oxford, 2001); A. Sanders ‘Victim Participation in an Exclusionary Criminal Justice System’, in C. Hoyle and R. Young (eds.), *New Visions of Crime Victims* (Oxford: Hart, 2002); M. Hall, *Victims of Crime: Policy and Practice in Criminal Justice* (Willan: Cullompton, 2009); A. Sanders (this volume).

⁶⁷ O. Quick, ‘Prosecuting “Gross” Medical Negligence’, 429.

⁶⁸ Ferner and McDowell, ‘Doctors charged with manslaughter’, p. 314.

seen that the ‘gross negligence’ test is too vague to act as a legal straitjacket. Indeed, ‘The CPS has told us that prosecutors find it difficult to judge when to bring a prosecution ...’.⁶⁹ So, prosecutors who wish to exercise discretion to prosecute when the evidence is ‘thin’, for example, will often be able to do so on the basis that drawing the evidential sufficiency line in such cases is a matter of judgement on which opinions can legitimately differ. So the mere existence of apparently strict legal rules does not negate the claims of Ferner and McDowell. In reality, those rules allow prosecutors considerable leeway. However, our data does cast doubt on the claims of increased prosecutions or, at least, of the lowering of the de facto prosecution threshold. There are several reasons to doubt these claims:

a) No evidence of an increase in prosecutions

Due to the ways in which cases are filed and stored, both we and the CPS lack data to show any reliable trends in medical manslaughter cases (see the appendix on methodology). However, in cases that the Medical Defence Union had dealt with over the past ten years, only five cases went to trial, of which three resulted in conviction⁷⁰. And in our trawl of all SCD cases over the six years 2004-9, of the seventy-five possible cases there were only four completed prosecutions, of which two ended in conviction.⁷¹ So on what did Ferner and McDowell base their claims of increased prosecutions? They were actually based on a search of newspaper reports. Ferner and

⁶⁹ Law Commission, *Involuntary Manslaughter*, para. 3.9.

⁷⁰ M. Devlin, ‘When an error becomes a crime’ (2010) 26 *Medical Defence Union Journal* 7-8.

⁷¹ We use the term ‘completed’ in the sense that the case was closed one way or the other. See Appendix for details.

McDowell could identify only one prosecution of a doctor between 1935 and 1975, for example. Is it really credible that there was only one such prosecution? Surely not.⁷² This is not a reliable source of data, as media content is of course highly selective, driven by consumer, social, political and economic interests.⁷³ We could find no media coverage of many of the medical manslaughter investigations that we have looked at within the CPS, and have found that some prosecutions, particularly earlier ones, e.g. one that occurred in 1990, did not feature within media reporting. This is particularly so for victims who do not possess the ideal characteristics that would make a story particularly newsworthy. For example, we could find no media coverage in the case of a terminally ill eighty-year old woman whose death was caused by the momentary error of a surgeon. Although the death of a baby after a surgical procedure garnered huge press attention despite no fault being found. It is likely, precisely because of the developing culture of distrust in professionals, referred to earlier, that such cases, which would not have merited media attention decades ago, are now deemed to be of general interest. Moreover, Ferner and McDowell provide no other support for their claims of increased prosecutions since 1995: their statement that ‘... the 1990s saw a marked increase in the number of doctors charged with manslaughter’ has two footnotes in support. But both sources are short ‘news’ pieces in the BMJ that base assertions of increased prosecutions on an earlier article by Ferner in the BMJ. Ferner and McDowell’s article simply widens the search used in

⁷² S. O’Doherty, ‘Doctors charged with manslaughter in the course of medical practice 1795-2005: A response’, unpublished, p. 3.

⁷³ D. Griffiths and A. Alghrani, “‘Criminal’ Healthcare Professionals: Medical Malpractices and Public Perceptions’, unpublished. See also M. Brazier, ‘Times of Change?’ (2005) 13 *Medical Law Review*, 1, 1-16.

Ferner's earlier research, using the same methodology.⁷⁴ Ferner and McDowell are therefore on their own in their claims of increased prosecutions since 1995, which are, we have seen, based on a methodology that we know is unreliable.

b) Increase in prosecutions but no lowering of threshold

There is little doubt that there has been an increase in the number of coronial inquests and police investigations in these kinds of cases.⁷⁵ Any increase in prosecutions that there might have been could be because more strong cases present themselves to the CPS than was so ten or more years ago. One reason for this could be that as the NHS and the number of complex near-death cases have expanded (advances in medicine prolonging the life of people who would have died only a few decades ago), there are more opportunities for fatal error than there used to be. Also, the culture of distrust and the increased willingness to listen to victims, that Quick and other commentators use to justify the belief that prosecutors prosecute more readily, along with Article 2 ECHR, can be seen to have a different effect: these have probably driven the police and coroners to investigate more cases (as is evident from the cases discussed in section 4 (iii) and (iv) below). This could have produced more prosecutable cases for the CPS to deal with than hitherto i.e. cases that would not have come to light as

⁷⁴ R. Ferner, "Medication errors that have led to manslaughter charges" (2000) 321 BMJ 1212. The articles that cite this may be found in (2002) 325 BMJ 63 and (2003) 327 BMJ 1118. For further discussion of the methodology see S. O'Doherty, 'Doctors and manslaughter – response from the Crown Prosecution Service' (2006) 99 *J. of the Royal Society of Medicine* 544.

⁷⁵ O. Quick, 'Medical manslaughter: The rise (and replacement) of a contested crime?'. He found forty investigations in 1996-2005, compared with seven in 1976-85 (p. 33).

potentially prosecutable many years ago. If criminal investigations are increasing, and are largely driven by families and coroners' concerns, this alerts us to the probability that redress and accountability is increasingly being sought through the criminal process.

c) Convincing the jury

The evidence that we will present below indicates that the CPS seems to have difficulty in prosecuting MM cases in general, and that it does its best to ensure that a case is robust. We shall see that, rather than being keen – and more keen than in the past – to prosecute, the CPS is actually reluctant to prosecute. This is often borne out of the awareness that judges and juries do not like having these cases, particularly doctors, in front of them and to quote one prosecuting lawyer, 'we often have to go that extra hurdle to ensure that the case is not going to fall at half time'. While the low conviction rate in medical manslaughter cases⁷⁶ could indicate a low evidential threshold, the more likely explanation is that trials for medical manslaughter are particularly precarious. Our analysis and interviews have shown that at trial, a case can very easily fall after for example, a new defence hypothesis as to the cause of death, fresh unforeseen evidence and witnesses (who are notoriously unreliable in medical cases) failing to perform well. For example, in one prosecution that we looked at, despite the evidence being perceived as strong pre-trial, the doctor was acquitted. The prosecuting lawyer on the case stated that the major reason for the not-guilty verdict was the fact that the main prosecution witness did not come up to proof

⁷⁶ Quick puts this around forty percent

in the witness box, despite being strong in her previous statements and the prosecution's main expert witness faltered in their evidence in court.

A police doctor was recently put on trial for medical manslaughter after a man held in custody died. The man was a heavy drinker, had epilepsy and schizophrenia and had banged his head and become unconscious during his arrest; the doctor examined him for less than a minute in his cell, failed to try to rouse him and did not take any kind of medical history. Despite such obvious failures in care, the jury found him not guilty arguably related to the reluctance of juries to convict.⁷⁷

As O'Doherty states:

Patients see doctors because they are ill, possibly from multiple disorders.... When faced with a defence hypothesis as to the cause of death, prosecution experts may, quite properly, concede that such a hypothesis cannot be excluded and because of the heavy burden of proof on the Crown, the prosecution may offer no further evidence. Fresh evidence may arise during trial which cannot be foreseen and witnesses may fail to come up to proof but that does not mean that the CPS decision process had failed⁷⁸.

Only about five percent of MM cases investigated proceed to a prosecution, this is, by any standards, a low figure. It appears that, rather than too many cases being prosecuted, there could be too few cases prosecuted. We now go on to assess this possibility and look at why this might be.

⁷⁷C. Dyer 'Police doctor is cleared of manslaughter but criticised as "negligent"' (2012) 344 BMJ 739.

⁷⁸ S. O'Doherty, 'Doctors charged with manslaughter', unpublished, p. 3.

4. Prosecution decision making in England and Wales in relation to health care deaths

We looked at seventy-five CPS cases in total and have categorised the decisions within those files into five groups.

a) No decision

In seven percent (five cases) no decision was made by the CPS. All of these files were advice files, where the police had referred the brief circumstances of a case early on in order to ascertain whether a full investigation was required and the case had subsequently been closed without gathering such evidence. In all of these cases the CPS prosecutor had suggested what further evidence could be collected, and gave advice on how to collect that evidence. The police exercised their own discretion in deciding to close these cases.

Whilst we cannot make firm generalisations on the basis of just five cases, we can make tentative links between these cases and the uneven application of police discretion and case construction by prosecutors⁷⁹. For example, the victims in two of these cases were drug and alcohol users, and in the other three they were elderly patients. There appeared to be no family involvement in these cases. In other words, there was no pressure to conduct full investigations, and police (and perhaps CPS)

⁷⁹ Griffiths, 'Medical Manslaughter and the Decision Making Process'.

evaluations could have been that the cases concerned the opposite of ‘ideal victims’⁸⁰ and therefore embodied a relatively small public interest in prosecuting. For example, in one case involving an elderly patient, despite there being clear evidence that the death could have been avoided but for the actions of the doctors involved, the police closed the case as ‘it was likely to take up more resources than we could bring to bear on it’. In a case involving a young man, who was a drug user, the file made repeated mention to the fact that this was an ‘unhappy, difficult and troubled young man’. The man was wrongly prescribed drugs in a quantity that was too much for someone who had previously attempted suicide several times. The police had gathered very little material which was submitted to the CPS, who advised on the basis of such little evidence ‘that it looks like there would be no case’ and the police did not continue with the investigation.

b) Prosecution – all tests met

In five percent (four cases) the CPS decided that the evidential and public interest tests were met and therefore prosecuted. Of these cases there were two convictions and one acquittal. One case never got to trial as defendant fled the UK and could not be extradited.

In one case that was prosecuted there was strong evidence in the file that the doctor was warned by colleagues not to proceed with a procedure. In another prosecution, the doctor was warned by the patient that she was allergic to a certain drug. Despite such warnings the doctors went ahead. Another doctor who faced

⁸⁰ On ‘ideal victims’ see e.g. B. Hudson, ‘Restorative justice: The challenge of sexual and racial violence’ (1998) 25 *Journal of Law and Society* 237.

prosecution killed his patient by giving an overdose of a routinely used painkiller. Her behaviour was deemed grossly negligent (indeed reckless) due to the facts, among other things, that a) prior to seeing the victim, she had given an overdose to another patient (who survived); b) the victim was given the diamorphine for a simple ailment; c) she had given the thirty mg dose in one go as opposed to the normal procedure of administering a dose at one mg per minute; and d) she failed to stay with his patient for the minimum of thirty to forty minutes as is normal when morphine has been administered by a GP. Finally a doctor was deemed to have used grossly excessive force in using forceps to deliver a baby, and continued to use such force despite the fact that the patient, her family and other nursing staff warned against proceeding with a forceps delivery. The prosecution did not proceed as he fled the UK and could not be subsequently extradited.

In all of these cases, establishing a breach of duty and causation seemed from the prosecution files to be relatively unproblematic and agreed on by the experts who were consulted. In assessing the grossness of the breach, in all cases there appeared to be subjective recklessness. In none of these cases did moral culpability appear to be low. Additionally the language used in some of the files denoted that the health care professional involved displayed an element of additional ‘bad’ character. For example, a prosecutor described how one doctor displayed great arrogance and little remorse. In another case, the file described in detail the personal problems that the doctor was experiencing at the time she made her fatal mistake. Many prosecutors told us that such elements of ‘badness’ were often crucial in securing a guilty verdict. To quote one lawyer, ‘you need something more than a serious error of judgement; you need something ‘dirty’ something the jury can latch on to’.

At trial, the picture changed to varying extents in these cases, as it always does after the defence gives evidence, particularly surrounding issues of causation.

c) No breach of the duty of care

In twenty (twenty-seven percent) of the cases, no breach of duty of care was found in relation to the individuals being investigated.

i) In around half of these cases it was clear that there would be difficulty identifying a breach from the beginning. For example, a nine-week old baby bled to death after a routine circumcision. The post-mortem was inconclusive as to why the bleed occurred and there was no evidence that the operation was performed negligently. Despite the early finding that causation could not be proved, a full one and a half year police investigation was initiated, after which it was concluded that there were no grounds to argue that the GP who performed the operation had breached his duty of care. Like the other cases in this category it proceeded to a full police investigation and SCD review despite it being obvious from a very early stage that the evidential threshold would not be reached. This raises the question why these cases did not fall into category (a) above i.e. an initial investigation that was not pursued in depth because of lack of evidence of an essential element of the crime. There are three possibilities, which may arise singly or in combination, in any one case:

- because of ‘right to life’ obligations and associated coronial investigations (see section 1) many cases are investigated more thoroughly than would appear necessary;

- it is not necessary to exhaustively investigate if the police and CPS are sure that there is no crime or that the culprit cannot be apprehended or that they cannot secure sufficient evidence. But this requires early communication of the case by the police to SCD. Many police officers, in some of these cases, it appears, and in general, are unaware of this possibility;
- some cases seem to have been pursued at length because of family pressure on the police and/or media interest.. One such case was the example above. The case garnered immense press attention and the tragic nature of the death was reiterated through the file. Another case had been ongoing for over seven years and had been pursued by a relation of the deceased who had used his own money in order to seek a judicial review, despite the fact that from the beginning there was little evidence that the doctor had even breached his duty of care. In our interviews, several prosecutors noted to us that the police can often be over influenced by family pressure and pursue an investigation in more detail than they would otherwise. One prosecutor noted that this will often serve to ‘give the family false hope that there will be a trial and also raise suspicion that there must have been some wrongdoing’. The cases in category (a), by contrast, appear to have been subject to no family pressure or media interest.

ii) In a third of the cases where no breach of duty was established, there was clear evidence of individual error. Three cases involved individual faults that contributed to a death yet no one individual could be identified as the cause of the particular error/incident. For example one case involved a toddler who died after a naso gastric tube was inserted into his lung and feed was introduced. Three nurses were involved

in his care but not one admitted making the mistake. One of them was almost certainly to blame but it was impossible to identify which one.

iii) The rest of the cases involved errors or adverse incidents that could be directly related to systemic faults. For example, a man was refused treatment on arrival at an A and E department: the hospital staff had deemed that he posed a threat to staff because they believed he was using drugs and had shown slight aggression. He was taken to a police station where he suffered a cardiac arrest and died. The police investigation concluded that he did not have capacity on arrival at the hospital (he was suffering from ‘excited delirium’ in relation to his drug use) and should have been sedated and treated on the basis of his severe symptoms. Three individuals were investigated but Trust policies on ‘violent and aggressive behaviour’ had never been communicated to the individuals or tested, so no individual breaches of duty were found.

d) Failure to establish causation

Thirty-three (forty-four percent) of the cases failed on causation. We stated in section 2 that causation is particularly problematic in MM cases. This is because, by definition, they involve cases where the victims are already ill or injured and so at greater risk of death than ‘normal’ people. Even when someone has a non-life-threatening condition, the administration of an anaesthetic⁸¹ or drug to which they have an undisclosed allergy, or their exposure to hospital ‘superbugs’, can lead to

⁸¹ See Lyons (this volume).

unexpected death without any negligence at all, let alone gross negligence. Vulnerable patients, particularly the elderly and the terminally ill, are (by definition) more vulnerable. Not only are they more susceptible to ‘things that go wrong’ (such as operations, allergies and exposure to superbugs), but they usually present to hospital with a series of existing ailments. In one case the pathologist concluded ‘establishing causation in the case of an eighty-five year old woman with a history of heart disease is near impossible even if gross negligence was present’. This was despite the fact that the woman had died following extreme failures in the level of nursing care. We identified different types of case where causation was impossible to prove:

i) Only four of these cases could be said to involve no evidence of a fault or error.

Like the cases in category (c) (i), these cases did, again, appear to be pushed forward more than appeared necessary by family pressure etc., even taking into account the need for Article 2 ECHR compliance. For example, a baby born at twenty-five weeks died due to natural causes. A doctor treating the baby had made a minor error which was found to be unrelated to the cause of death yet the police still pursued a lengthy investigation after the family had raised concerns. In a similar case where a baby died of meningitis, despite it being evident early on that causation would be very difficult to prove as the baby’s condition when he first presented in hospital was quite advanced, the police investigation was pursued in full over a two-year period.

ii) The breach of duty in five of the cases (in our opinion) *could* have reached the threshold for gross negligence if causation could have been established. In two cases there was evidence of extreme negligence, and there were no mitigating factors that would have made appraisal of ‘all the circumstances’ lead to the conclusion that the

defendant's behaviour was insufficiently 'bad' for the criminal standard to be reached:

- a baby died five days after birth due to serious omissions by one midwife in the management of pre-labour and labour, including lack of treatment of worsening symptoms in the mother over a two day period. Establishing causation was extremely complex and ultimately failed due to the experts' reluctance in concluding beyond reasonable doubt that but for the midwife's numerous acts and omissions, the baby would have survived;
- a doctor accidentally administered four times the dosage of dopamine to an elderly patient, the effects of which 'contributed to the death' but could not be confidently said to have been a significant cause in this terminally ill patient.

In 3 cases there was evidence of subjective recklessness. For example:

- a surgeon proceeded with a non-essential operation despite knowing that the patient was at serious pre-operative risk and then failed to adequately treat her when she suffered a cardiac arrest during the surgery;
- a nurse failed to treat an elderly woman who had suffered a non-life threatening injury to her left foot and who progressively deteriorated due to the lack of care, despite the nurse being warned of the deterioration. Existing medical conditions meant that the cause of death was not established.

iii) In some of the cases, the level of a breach of duty of care would probably not have reached the threshold for grossness yet arguably the behaviour at stake went

beyond the civil level of negligence. For example, a diabetic man was admitted to hospital suffering from a urinary tract infection and septicaemia. He was given antibiotics and was described as sleepy and confused. Despite this, a nurse allowed him to self-administer insulin and he subsequently went on to take three times the usual dose and was found unconscious. He died three days later from pneumonia and while the experts concluded that the insulin overdose was a significant contributory factor, two of the experts would not commit to being sure that, but for the overdose, the patient (who was elderly) would not have contracted pneumonia and died.

iv) Other cases involved serious systemic failures. For example, a registered nurse provided home night care to a terminally ill baby. The nurse was employed by an independent nursing agency which had not checked on her background or qualifications. Whilst the nurse's actions were clearly negligent, she had asked the agency why she was being sent to the patient's house on that night when she was inexperienced in paediatric care but felt she would lose her job if she refused. Thus 'in the circumstances' of her inadequate qualifications and training it could justifiably be said that her negligence was not 'gross'. Systemic failures such as occurred in this case should prompt consideration of prosecution for corporate manslaughter. But there is the same need to prove causation as in 'normal' MM. In any event, the particularities of the common law offence (which was applicable at the time of this case) and the new corporate manslaughter law, make corporate prosecutions in medical cases almost impossible except in the most extreme cases.⁸²

⁸² For discussion see Wells (this volume).

e) Failure to reach 'gross' threshold

Thirteen (seventeen percent) of the cases fell into this category.

i) A quarter of the cases included evidence of subjective recklessness yet there were 'circumstances' (that could be characterised as 'mitigating') or other reasons why they were judged not to meet the 'gross' threshold. For example, a surgeon perforated a major organ during an operation to take a biopsy and the patient subsequently died. Nurses attending the operation stated that they expressed worries to the surgeon about the procedure. Subsequent investigations showed that the particularly difficult nature of the operation meant that the perforation that caused death was understandable. The surgeon knowingly took a risk that may or may not have been justified, but it was not a grossly negligent decision 'in the circumstances'. Other cases involved failures in care by a number of individuals yet none of which individually reached the threshold for gross negligence. To quote a common theme within many of these files, despite a case being caused by minor and reckless failures by a number of individuals, of these failures could not be summed in order to reach the threshold required.

ii) In about half of the cases there was clear evidence of gross negligence on our interpretation. In all of these cases, the CPS took into account circumstances that could be characterised as 'mitigating', which were said to have affected the healthcare professional's behaviour e.g. pressure, stress, end of long shift. For example, in one case a doctor accidentally inserted a chest drain into the patient's heart causing a catastrophic and fatal haemorrhage, and in another a nurse mixed up two bags and accidentally and fatally administered a pain relief infusion intended for epidural use

into a patient's arm (he was pronounced dead 1 hour later). Both healthcare professionals were said to have worked very long shifts without adequate breaks due to understaffing and had previously displayed exemplary character and work. Another example included a nurse who incorrectly placed a naso gastric tube into a patient's lung, yet this failure was found to be a result of poor practice that had developed on the ward and was condoned by clinicians and more senior management. The nurse was described as a hard working and dedicated professional who had never displayed any previous bad character.

iii) Finally in around a quarter of cases in this category, the incidents and errors that occurred lacked any evidence of mitigating circumstances or systemic issues. In most of these cases it was clear that the CPS were reluctant to prosecute because there was little evidence of subjective recklessness. In many of the cases, incompetence rather than deliberate wrongdoing was blamed. Examples include a GP who, over a period of two months failed to diagnose an infection in a young child. Despite the child's dramatically worsening symptoms, the GP failed to chase urine tests or make an urgent referral. The prosecutor concluded that the failings of this doctor demonstrated a 'clear need for assessment and further training within the field of paediatrics'. It was noted that this was a 'tragic mistake by a dedicated professional'. Two nurses had caused the death of a diabetic patient due to incorrect treatment for hyperglycaemia. The errors were put down to a lack of experience and failure to check the original prescription rather than a 'wicked and abysmal act'. The rest of the cases involved a momentary error on the part of an otherwise competent practitioner A doctor fatally administered an excess of a particular solution during an operation. The file concluded that 'this was a tragic mistake by a dedicated professional with fatal

consequences'. A doctor had accidentally given a fatal overdose of drug to a patient but the review note concluded that the doctor had clearly 'made a mistake which he has now recognised but the breach of duty was a serious error of judgement rather than a gross and therefore criminal act'. The note makes reference to how remorseful the doctor has been, how his motivation had been clearly to act in the best interests of his patient and how the family are very sympathetic towards the doctor and are aware he had done his best to care for their relative. In another case a doctor had wrongly prescribed a drug which led to the death of her patient. The review note concluded that 'this appears to be a tragic error of misjudgement by the professional involved' not a criminal breach of duty and her previous good conduct, and the fact that she had previously on that day issued the right dosages of the same drug, went in her favour.

It is hard to escape the conclusion that in many or most of these cases the public interest test was being applied under the guise of the evidential test; and/or that in cases such as these the two tests merge. The tests could merge because juries would be expected to have the same feelings of sympathy towards the health care professionals in question that the prosecutors expressed (e.g. 'tragic mistake by a dedicated professional'). Acquittals would therefore have been likely even if all the elements of *Adomako* were satisfied.⁸³ It will also be evident that many of these cases included systemic aspects, Many of these files very briefly considered a charge of corporate manslaughter but as all of the cases we looked at occurred before the creation of the 2007 Act, the difficulty of identifying a 'controlling mind' that was

⁸³ 'Jury equity' is a recognised feature of jury decision making i.e. some acquittals are made in the face of evidence of guilt because of sympathy for the defendants and/or dislike of the criminal law under which they were prosecuted. For discussion see Sanders, Young and Burton, *Criminal Justice*, Ch.10.

reckless or negligent meant that such a charge was ruled out very early on. It is unlikely that the new Act would have made a difference in these cases. Again, prosecutors and juries can be expected to have more sympathy with health care professionals who have been let down by their organisation, or put in an invidious position by it, than with people who put themselves in these positions through greed or wilful carelessness.

The prosecutors in these cases would argue that they are simply applying the evidential test: that it was more likely than not that gross negligence could not be proved and/or that the '5th element' ('badness') could not be proved when 'all the circumstances' are taken into account. Such circumstances include long shifts causing tiredness a momentary slip or error, and lack of experience. But the stress by prosecutors in many of these cases on incompetence rather than deliberate wrongdoing seems irrelevant when prosecutors need not prove subjective recklessness; and the stress on 'exemplary' character and past record seems irrelevant when 'badness' needs to be found in the act, not the person. In other words, prosecutors seem to be searching for something beyond what we might term 'threshold gross negligence' in order to prosecute. This might be for the following reasons, alone or in combination:

- they perceive a legal obligation produced by the '5th element' to prosecute only when there is evidence of culpability substantially above that threshold;
- they think there is no reasonable prospect of conviction by a jury, despite what might be enough evidence in theory, where culpability is not substantially above that threshold;

- they have no wish to prosecute in cases where culpability is not substantially above that threshold, and so apply the ‘public interest’ test under the guise of the evidential test.

This can all occur because of the vagueness and circularity of the ‘gross negligence’ test. The ‘5th element’ is only one aspect of this, but it seems to be a particularly important one in the light of phrases such as ‘wicked and abysmal act’ that are used in the search for ‘badness’.

5. Alternatives to medical manslaughter by gross negligence

To summarise so far, we have seen that interest in the use of criminal sanctions for medical error was sparked by the claims that a) prosecutions are increasing; b) this is because the CPS has been lowering the threshold for prosecution in response to public pressure; and c) altering the threshold is facilitated by the uncertain tests for GNM created by *Adomako* and subsequent cases. The empirical research carried out to test these claims found that whilst (c) is undoubtedly true, the vagueness of the tests allows the threshold to be raised as well as lowered. Far from finding excessive numbers of prosecutions, we found remarkably few. While we cannot definitely conclude from our relatively unsystematic sample of cases that prosecutions have not risen, we found no evidence that they have done so. It is true that there is increasing public pressure, particularly from victims’ families, to invoke the criminal process, and this does seem to have led to more police investigations and protracted inquests. But rather than prosecutors lowering the threshold in response to pressure, we found that thresholds were sometimes higher than they needed to be. However, the main

reason for the lower-than-expected number of prosecutions was not the generous exercise of discretion by prosecutors, but the nature of the GNM tests and the particular circumstances in which MM occurs. These circumstances are, primarily:

- i) The dead people are generally at risk of death even before they get into the hands of the accused, thus often making causation impossible to prove.
- ii) As with corporate killings, many medical deaths occur as a result of a chain of relatively small mistakes. At any point in that chain of events a good decision would have averted catastrophe. Thus the contribution of each individual is often either impossible to determine or so small that it cannot be said to be a substantial cause of death.

These conclusions lead us, perhaps surprisingly, to consider not how GNM should be reduced in scope in cases of medical error, but how it might be increased. The purpose would be both to acknowledge the legitimacy, at least in some respects, of public concern; and to punish behaviour that in other contexts would be likely to be punished.

Reckless manslaughter

Quick argues that reckless manslaughter – based on a largely subjective test – would be a good substitute for GNM in general. He argues that this would set the level of liability at an appropriate level, and would offer greater certainty for prosecutors, judges and juries who currently struggle with the vague and imprecise notion of gross

negligence. Raising the bar of liability from gross negligence to recklessness would also, he argues, reduce the number of prosecutions against healthcare professionals. Whether, in the light of our argument that prosecutions are currently neither increasing nor inappropriate, Quick would change his view, remains to be seen. As it is, his view is that a positive feature of reckless would be that:

where a doctor has special knowledge that certain procedures carry with them certain risks, and fails to investigate those risks without justification, criminal responsibility can be properly attributed on the basis of recklessness⁸⁴

However, a defendant's subjective awareness at the time of an incident is not easily proved. The fact that health care professionals have special knowledge and *should be* aware of the risks of death in a particular situation does not mean that proof that they were aware could be proven without objective evidence (e.g. ignoring warnings). Without objective evidence, evidence of gross negligence will be used, as it is in other cases, as evidence that the defendant *must* have realised what is being alleged. Thus Quick cites a prosecutor who says 'I can't see how we would bring a prosecution without an element of subjective recklessness ... even if there's no direct evidence of subjective recklessness ... but it may be so blindingly obvious that anyone must have realised ...'.⁸⁵ But what may be 'obvious' to a prosecutor working on the basis on a

⁸⁴ Quick, 'Medicine, Mistakes and Manslaughter', 202. Note that in this way he, following Tadros, 'The limits of manslaughter' and Duff, *Intention, Agency and Criminal Liability* avoids falling into the subjective/objective dichotomy trap identified in section 2.

⁸⁵ Quick, 'Medicine, Mistakes and Manslaughter', 193.

paper file will often not be obvious to a jury following oral evidence and hearing the defendant. So instead of the jury guessing what is meant by ‘gross negligence’ and whether this accurately describes the defendant’s behaviour, with a subjective recklessness test the jury will have to guess whether what was obvious with hindsight was actually perceived by the defendant.

Creating a recklessness test would eliminate those cases where moral culpability is low such as in *Sullman and Prentice* and the case of Dr Falconer.⁸⁶ However, only around six percent of cases in our analysis raised such familiar questions surrounding criminal liability for negligence and could be said to be the typical momentary slip (for example, the doctor who through a momentary error fatally administered the wrong drug to a baby and the doctor who accidentally pierced a patient’s heart when inserting a chest drain). It was clear from the case files that we accessed, the CPS were reluctant to prosecute medical cases where moral culpability is questionable – ‘dubious cases on the cusp’⁸⁷ – particularly where there were mitigating circumstances and where the incident was a momentary lapse on the part of an otherwise exemplary doctor or nurse. None of these cases proceeded, in contrast to those cases where there was evidence of recklessness (without mitigating circumstances). Whilst the law surrounding gross negligence may be unclear, the CPS decision making that we analysed in this area was certainly consistent.

The case for a recklessness test rests in part on the arguments of principle against GNM by gross negligence discussed in section 2. The first of these was moral

⁸⁶ *R v. Prentice; R v. Sullman* [1994] QB 302. Dr Falconer was prosecuted and acquitted for what appears to have been a momentary slip: *The Times* 19 May 2004.

⁸⁷ O. Quick, ‘Medical killing: need for a special offence?’ in Clarkson and Cunningham, *Criminal Liability for Non-Aggressive Death*, p. 165.

luck: why punish harm caused inadvertently and only when, by a chance of fate, it causes death? The first part of this argument applies to all ‘result’ crimes (such as ‘causing’ GBH) and the second part applies to all forms of involuntary manslaughter (the clue is in the term ‘involuntary’). And indeed many murders.⁸⁸ Second, it is sometimes thought wrong to criminalise behaviour done grossly badly but with good motives. But this argument would apply to many other areas of life, such as the employer whose poor safety standards cause death. In *Holtom*,⁸⁹ for example (to simply take the most recent case to come up on a *Westlaw* search) a fifteen-year old boy died when a wall fell on him. He had been demolishing the wall for his employer, the defendant, without training, safety equipment or supervision. The defendant had been told the wall was leaning. Perhaps he was subjectively reckless, though it is not clear that this could have been proved. But he was clearly grossly negligent. Related to this argument is the view that the coercive punishment unique to criminal law requires that subjective risk-taking or intent to do harm be proven. But if this were so, a huge range of lesser offences would be de-criminalised (e.g. road traffic offences, health and safety etc.). Moreover, in recent years the case for subjectivism in more serious offences has been challenged by the problems of securing convictions in sexual offences. Thus proof of rape no longer requires subjective awareness that the victim was not consenting. Specific problems are sometimes seen as justifying specific solutions. Sexual crime is one such, and so is gross medical malpractice.

Changing the bar of liability to subjective recklessness would have little impact on the decisions made in the cases we had access to. Of course, the cases we looked at covered a relatively short period and there is certainly case law to show that

⁸⁸ Intent to cause GBH will suffice for murder: *R v. Cunningham* [1982] AC 56.

⁸⁹ *R v. Holtom* [2011] 1 Cr App R (S) 934.

CPS prosecutors have not always displayed such reluctance, as cases such as *Sullman and Prentice* and in the case of Dr Falconer⁹⁰ demonstrate. But cases like these are rare, and appear to be in the past (prior to *Rowley* and *Misra*, discussed in section 2). There is no need to change the bar in order to prevent prosecution of momentary error because prosecutors have in effect done this already by adopting the ‘5th test’ in the last few years. We should, in any event, resist making changes that will have widespread effects because of a few difficult cases. Nearly all of the prosecutors and defence lawyers we interviewed stated that the test for objective liability was essential in order to capture those cases which, however rare, were criminally culpable.

Whether or not a recklessness-based form of MM would provide more certainty than GNM does, it would not cover cases in category 4 (iv) above: where causation could not be proven. And, insofar as much uncertainty would remain (in cases where evidence of gross negligence was relied on as evidence of recklessness), this uncertainty could still be used to ‘smuggle’ in ‘public interest’ considerations under the guise of the ‘evidential’ test. Finally, it would not cover professionals who were hugely reckless but whose acts or omissions did not cause death (see later).

A context-specific revised version of GNM

Ashworth suggests that negligence tests may be appropriate where the harm is great, the risk of it occurring is obvious, and where the defendant has both the duty and

⁹⁰ Dr Falconer was prosecuted and acquitted for what appears to have been a momentary slip. He mistakenly injected air into a baby’s bloodstream during a routine stomach operation: *Times* 19 May 2004.

capacity to avoid the risk.⁹¹ The applicability of these criteria to MM (although they were not formulated specifically for it) is clear.

Brazier and Alghrani argue, in the light of critiques such as that of Quick, that the challenge then becomes to propose a more substantive test for MM. They go on to offer an expansion of the four-part *Adomako* test:

(1) Did the alleged negligence fall short of responsible professional practice so as to engage liability in tort?

(2) Did the doctor show indifference to an obvious risk of serious injury to his patient? If the answer is yes, his negligence is gross, as he has failed altogether in his duty to his patient, and in his lack of regard for others' welfare his conduct equates to deliberate wrongdoing, irrespective of external circumstances or his own capacities.

(3) Was the doctor aware of such a risk and nonetheless exposed the patient to that risk for no accepted medical benefit? If the answer is yes, his negligence is gross unless there is overwhelming evidence of significant mitigating factors, for example that the doctor was working in circumstances that substantially impaired his ability to provide adequate care for his patient.

(4) Should the doctor have been aware of such a risk and, if he was not, did his practice fall significantly below the standard required by responsible professional opinion? If the answer is yes, his negligence is gross unless there

⁹¹ A. Ashworth, *Principles of Criminal Law*, pp. 187-8.

is evidence of significant mitigating factors, for example that the doctor lacked the experience or capacity to deliver the treatment in question.⁹²

This would, to some extent, meet Quick's concerns about the threshold for MM and the lack of certainty in the 'gross negligence' test, but it only goes so far along the path he advocates. If, as he suggests, prosecutorial policy became more clear and explicit about the mitigating circumstances which are taken into account when considering (objective) medical errors, his concerns would be further allayed.⁹³

Leaving prosecutorial policy to the discretion of the individual prosecutor can result in unfairness and uncertainty for the health care professional and victim/relatives. Even if there is no prosecution, as is usual, the period of waiting during a lengthy investigation must be gruelling. This was recognised in relation to assisted suicide, and detailed guidance for prosecutors has been published. This sets out the factors taken into account in deciding whether or not to prosecute.⁹⁴ So although the CPS still has to consider, in each assisted suicide case, whether or not to prosecute, victims, suspects, prosecutors and the public all know the basis on which decisions will be made and can now make reasonable predictions what they will be. The same could be done in relation to MM.

⁹² M. Brazier and A. Alghrani, 'Fatal Medical malpractice and Criminal Liability' (2009) 25 *Jo Professional Negligence* 51-67.

⁹³ Quick (2007) op cit at p. 190. But This would not satisfy Quick, for whom the vagueness of the gross negligence test remains a fundamental objection.

⁹⁴ See the DPP's 'Policy for Prosecutors in cases of assisted suicide' (http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy), discussed in Sanders (this volume).

However, from our point of view the problem of causation would remain in Brazier and Algrhani's revised version of MM, and if a prosecution policy is formulated and published, and even if both were done. In other words, these would be welcome reforms but they are not the only desirable ones.

A context-specific offence of 'medical neglect endangering life'

A context specific negligence based offence for health care could offer a fairer and more nuanced approach to using criminal law in this area. Road, work and familial homicide now warrant separate offences.⁹⁵ Yet, Quick argues, creating such a context specific criminal offence for dealing with fatal medical error would depend on a well understood typology of error, and its relationship with individual blame.⁹⁶ Medical errors are more variable and complex than those associated with driving or domestic violence and while there are useful classifications of medical errors,⁹⁷ Quick notes that the systematic study of error is at this time insufficiently well developed and has certainly not filtered down to prosecutors. This uncertainty surrounding a taxonomy of medical errors would, for Quick, also apply to the creation of offences of carelessly causing serious harm, or endangering life, in health care. However, it is not clear why this would be more of a concern in the health care context than in relation to health and safety at work or in relation to child neglect, to take just two examples.

There are several reasons why we should consider such an offence. Firstly, we have identified cases where there was clear evidence of recklessness but which fell on

⁹⁵ See the various papers in Clarkson and Cunningham, *Criminal Liability for Non-Aggressive Death*.

⁹⁶ Quick, 'Medical killing: need for a special offence?'; Quick (2008) op cit.

⁹⁷ Merry and McCall Smith, *Errors, Medicine and the Law*.

establishing causation. For example, the surgeon who proceeded with a non-essential operation (nose reshaping) despite knowing that the patient was at serious pre-operative risk: the severe harm that was inflicted was not in doubt, whether or not it could be proved beyond reasonable doubt to have caused the death. Serious omissions by a midwife in the management of pre-labour and labour, despite being given warnings, also caused serious harm according to the expert evidence in the case. And then there was the nurse who, despite warnings, deliberately failed to treat an elderly patient who had suffered a non life-threatening injury to her left foot. Secondly there were those cases where there was evidence of neglect that fell on causation and failed to meet the threshold for criminal negligence. For example, the elderly diabetic man described as ‘confused and drowsy’ who was allowed to self-administer insulin and subsequently went on to take three times the usual dose. Thirdly there are those fatalities that have resulted from a number of individual errors/failures/incompetence but no one individual error can be said to have caused the death or reach the gross threshold. There is still evidence of culpability here, just not high enough for medical manslaughter. Finally there are those errors stemming from systemic wrongdoing (e.g. failing to ensure a nurse has the necessary qualifications and training, and failing to ensure that there are proper procedures in place for the insertion of a naso-gastric tube) but which would fall on causation in any charge of corporate manslaughter, or fail due to the numerous difficulties with this offence generally. If we agree that the above range of conduct constitutes ‘substantial wrongdoing’ then this surely stands regardless of whether or not it could be established to have *caused* death or whether it meets the threshold for gross negligence or corporate manslaughter. Here then there is a case for using alternative criminal offences that do not rest on ‘grossness’ or causation.

Perhaps most important, what about the cases that nearly end up as homicide, but do not through sheer chance? Quick, along with other commentators, bases much of his argument against GNM on this point: that in most GNM cases it is purely a matter of ‘moral luck’ whether someone dies and thus whether there is the chance of criminal liability.⁹⁸ But if it is illogical to distinguish between those who survive by chance and those who do not, this would apply equally if we replaced GNM with his preferred ‘manslaughter by recklessness’ offence.

And the argument works the other way. If it is unfair that the only people who are prosecuted in GNM cases are those who are unlucky enough to cause death, fairness would be restored if people who are grossly negligent are prosecuted on the basis of their behaviour and the risk to life that it creates, regardless of whether they cause death.

Take the case of Jamie Merrett, a thirty-seven year old tetraplegic patient who relied on a ventilator to breathe. The ventilator was switched off deliberately by his nurse who, it appears, did not realise that the consequences could be damaging or fatal (she was a learning disabilities specialist, and was not trained to manage a ventilated patient). When the mistake was pointed out by a colleague the nurse attempted to resuscitate Merrett, but she carried out the procedure incorrectly. Paramedics managed to do it only twenty-one minutes after the ventilator was switched off, leaving Merrett with severe brain damage. Under current criminal law, neither the nurse, nor the agency employing her who did not ensure she had been trained appropriately, nor the NHS Trust, will be criminally liable. For at least one of these

⁹⁸ (2010) *Op cit*

parties that would not be so had Merrett died. Yet his suffering was indescribable.⁹⁹

Another example is the acquittal of a consultant urologist and a locum registrar, who were charged with manslaughter because a patient died after they removed a patient's healthy kidney by mistake instead of the diseased one.¹⁰⁰ They were acquitted because causation could not be proven, but they surely committed an error worthy of punishment. And Lisa Sharpe spent days in agony without pain relief because a doctor believed that she would die in two hours and, it seems, no-one cared sufficiently to check despite her mother's protests: 'They left her fighting for breath and in terrible pain. It was like watching someone drown before your eyes.' This was condemned by the health ombudsman but the neglect could not be shown to have caused Lisa's death.¹⁰¹

As Quick himself acknowledges, 'the absence of a lesser or inchoate crime renders this [GNM] an unsatisfactory "all or nothing" scenario.'¹⁰² Our proposal is therefore that an offence be created of 'medical neglect endangering life'. This would have the following elements, all of which would need to be proven:

- a) An act or omission (or, in the case of a hospital or trust, a systemic error) that endangered life (an objective test);

⁹⁹ It is reported that Merrett was aware that the nurse was switching off his ventilator as he could be heard making 'clicking' noises as a warning on a film taken by a camera installed at his request (because he had expressed concerns about the standard of care he had been receiving), *The Guardian*, 26 October 2010.

¹⁰⁰ C. Dyer, 'Doctors face trial for manslaughter as criminal charges against doctors continue to rise' (2002) 325 *BMJ* 63.

¹⁰¹ See Mencap, *Death by indifference* (www.mencap.org.uk) and *Guardian*, 3 January 2012.

¹⁰² (2010) *Op cit* at p. 186

- b) Committed by a health care professional in the course of his/her work;
- c) The act or omission or systemic error would have to be grossly negligent or reckless.

Similar crimes in relation to mentally ill and learning disabled patients are set out in the Mental Health Act 1983 and Mental Capacity Act 2005 respectively. Allen argues for these to be broadened in order to cover anyone owing a duty to someone else. This may be a good idea, and if such a broad law is enacted, our proposal will not be needed.¹⁰³ Meanwhile, however, there can be no argument that our context-specific crime would be inappropriate unless the same is said of the crimes in the Mental Health and Mental Capacity Acts. There is a legitimate concern about the proliferation of context-specific crimes and over-criminalisation in general.¹⁰⁴ So we need principles of criminalisation to ensure that each new offence created, especially context-specific ones, have special justification. Generally the justification is that such crimes are created in relation to especially powerful groups from whom specially vulnerable groups need protection. This is why children and the mentally ill, for example, are protected by context-specific criminal laws. But medical patients are in a similarly vulnerable position in relation to doctors and nurses. We also need clear published prosecution policies to ensure that only genuinely serious cases are prosecuted and that health care professionals need not fear prosecution where it would not be seriously contemplated.

¹⁰³ See Allen, (this volume). Allen's proposal requires recklessness, but does not require danger to life. There is insufficient space here to debate the pros and cons of these specifics.

¹⁰⁴ See, for example, D. Husak, *Overcriminalisation: the limits of the criminal law* (Oxford: OUP, 2008); Quick, 'Medical killing: need for a special offence?'.

The prosecution (or threat of prosecution) of a larger number of cases where there has been deliberate disregard or recklessness, as well as gross neglect, promises more of a deterrent effect than the prosecution of a few cases where chance as much as anything else makes a homicide prosecution possible. It is true that this deterrent effect may still be minimal as it probably is in relation to tort cases. There is also concern that use of the criminal law to punish medical negligence will increase ‘defensive medicine’ and reduce whatever culture of openness in admitting mistakes and learning from these mistakes has developed in recent years¹⁰⁵. However around two thirds of the cases we looked at arose through concerns raised by families and coroners, not through open admission of the healthcare professional or trust involved. In other words, the culture of openness is too limited at present to be worth preserving if the gains from alternative action are likely to be significant. Indeed, the number of deaths from incorrect administration of opiate medicines, for example, remains worryingly high despite well-publicised cases such as that of Dr Ubani. It is probably true that there could be better mechanisms of accountability than the criminal process, and that New Zealand, for example, has arguably introduced such mechanisms.¹⁰⁶ It is also true that many MM cases, prosecuted and not prosecuted, reveal serious systemic errors and might be more effectively and more appropriately dealt with as corporate killings. This includes *Adomako* where the defendant should not have been allowed to work, Lisa Sharpe (whose case reveals systemic neglect of the learning disabled) and

¹⁰⁵ Kennedy (chair) *Learning from Bristol: The report of the public inquiry into children’s heart surgery at the Bristol Royal Infirmary 1984-95* Cm. 5207(1) (London: HMSO, 2001).

¹⁰⁶ D. Griffiths and A. Alghrani ‘Criminalising Doctors: Lessons from New Zealand’, unpublished. This paper also details the case of Dr Ubani and discusses deaths from opiate medicines. See also Paterson (this volume).

the continued trail of vincristine deaths. But the prospects of the 2007 Act having teeth in practice, particularly in the medical context, are very small.¹⁰⁷ Whilst the UK lacks effective mechanisms of accountability at either organisational or individual level, we are left largely with individual criminal liability.

Despite the arguments in favour of retaining MM as it is now and creating a lesser included offence, the contrary arguments that we cite are substantial. However, these are arguments against *punishment* as much as they are against *criminalisation*. They focus on the need to learn from error and reduce bad behaviour, and rightly recognise that punitive processes are largely ineffective in these respects. However, as we flagged up in section 2, RJ provides an alternative approach – one that has the force of criminal law but the substance of civil and arbitral processes. There is no space to elaborate here,¹⁰⁸ but if prosecution guidelines are to be issued in relation to *when* cases are to be prosecuted, they could also set out *how they are to be processed*. Moreover, if RJ were used instead of punitive processes in all or most cases, prosecutors would be more willing to take formal action, and – when cases were prosecuted – juries would be more likely to convict, as the ‘punishment’ would be perceived to more readily fit the crime.

6. Conclusion

¹⁰⁷ P. Gooderham, ‘‘No-one fully responsible’’: a ‘collusion of anonymity’ protecting health-care bodies from manslaughter charges?’ (2011) 6 *Clinical Ethics* 68-77.

¹⁰⁸ For discussion, particularly of the stages of the criminal process at which RJ can take place, see Sanders (this volume).

Everyone agrees that GNN is problematic. Academics find it illogical, ill-defined and a matter of luck, as liability is often a matter of good or bad fortune. Practitioners have the same objection, with the added concern about the effect of just an investigation on their personal and professional lives, let alone a prosecution. Police officers spend considerable time investigating cases for which they have little or no expertise and which usually go nowhere, and prosecutors spend considerable time reviewing them. The down-sides of GNM are potentially particularly unfortunate in the medical context as we want medical professionals to be open about mistakes in the interest of preventing future errors, and we do not want medical professionals to avoid taking appropriate risks for fear of investigation and/or prosecution i.e. for defensive medicine to increase.

If Ferner and McDowell are correct that the CPS increasingly readily prosecutes MM, the damage would be great. However, we found no evidence for Ferner and McDowell's assertions. But we did find, as readers of their research would expect, that there are a very large number of investigations into whether or not MM should be prosecuted. Whereas Ferner and McDowell ascribe this to vindictiveness on the part of the CPS (and presumably the police, though they do not say this) we found no evidence of institutional vindictiveness. The probable increase in investigations is almost certainly due to Article 2 'right to life' obligations (whether real or perceived) and increased pressure from families and the media. The latter is probably due in part to increased knowledge of the legal possibilities on their part and increased willingness to challenge authority. It does seem that many of these investigations are pointless, at least in the depth to which they go and hence the time scale involved. Resources that would be better used elsewhere are used with no result, the shadow

cast over the lives of the professionals under investigation are unnecessarily protracted, and families are given false hope, with closure put off into a distant future.

Ferner and McDowell's concerns should not be ignored. But the concerns that our research have uncovered are equally worrying: numerous cases of gross neglect or recklessness that are not prosecuted because the inherent difficulties in GNM are exacerbated by the medical context and further exacerbated by prosecutors' reluctance to prosecute without – to put it crudely – 'badness' on the part of the suspect. The current law requires proof of 'bad' behaviour, not 'bad' health care professionals. People in medical care are very often weak and suffering from life-threatening conditions. This makes causation impossible to prove in many cases. For this reason, and because there are equally worrying cases that, by chance, do not end in death, a new offence of endangerment is needed. This would be a 'lesser included' offence for a revised form of GNM that should be subject to published prosecution guidelines – an offence with guidelines that had less potential to ensnare the merely unfortunate professional, but could still hold the worst practices to account. In many cases a shortened investigation into a possible GNM charge would be possible as the endangerment offence could be prosecuted instead. Thus closure would be achieved in many cases more quickly and more satisfactorily than it is now by the creation of an additional offence. We do not ignore the dangers of expanding criminal liability, but they would be mitigated if RJ were embraced as an alternative to punitive procedures.

There is a general principle that can be extrapolated from our findings and the argument we developed from them: that where particular groups have specific power over others there should be a rebuttable presumption that any substantial abuse of that power (whether deliberate or not) should be criminalised. Sometimes that power is

Bioethics, medicine and the criminal law: v2: Medicine, Crime and Society. Sanders, A. & Griffiths, D. (eds.). Cambridge University Press, p. 117–158

given by the State (as with the police and army). Sometimes it is a consequence of property rights and market power (e.g. landlords and companies). And sometimes it is because of their profession, as in the example of health care. And the effect of even more extensive criminal liability than there is currently on openness and defensive medicine? As one of our lawyer-interviewees said, health care professionals are far more worried about GMC and civil proceedings than about criminal prosecution, because the latter are so rare in comparison to the former. It is unlikely that our proposals, if enacted, would change this significantly.

Appendix: Methodology

A series of empirical studies were conducted as part of the wider AHRC project (see footnote 3) with three coroner's courts, police forces, the CPS and relevant lawyers. This paper primarily draws on an analysis of medical manslaughter case files drawn from the CPS's SCD. We examined how prosecutors make decisions in these cases, how they assess the evidential threshold, and finally, how far justice, deterrence and punishment are served by the current system.

We took a qualitative approach to the case file analysis, in order to gain an in depth understanding of the decision making process in cases of medical error. The cases all involved registered nurses and doctors employed in private hospitals, the NHS and in care homes and covered a six-year time period between 2004-2009. This period was used as the CPS did not hold accessible electronic databases on cases before 2004. All cases we looked at were closed (i.e. had been concluded). Case files consisted of advice files (where early advice on how and if to proceed with an investigation had been given to the police on the basis of initial scoping investigations rather than full investigation) and full review files (where the CPS had conducted a full review of the evidence gathered from a detailed investigation and either decided or advised on whether or not to proceed with a prosecution).¹⁰⁹

Cases are filed on their database under the date that the case closed rather than when the incident occurred or when the investigation was started. So our sample doesn't include all those cases that occurred but were not completed in that 6 year

¹⁰⁹ The 2003 Act that transferred the power to decide on prosecution to the CPS was brought in gradually, so the case sample covered both periods. In practice the police always followed CPS advice in these cases so the legal change was not significant for this research.

period (big cases such as the Gosport case, and cases such as Dr Urbani where there remained an extradition request) and also includes some cases predating 2004 that took a long time to complete (earliest case begun 2001).¹¹⁰ The CPS database also does not electronically store these cases under an exclusive category of medical manslaughter, rather the CPS had to search through a number of categories including death in custody and homicide in order to find these medical cases. Thus while seventy-five cases were found and made available to us we cannot be sure that our sample includes all the cases that occurred or were closed in that six-year period.¹¹¹ We therefore cannot draw any conclusions about any increases or decreases in the number of cases referred to the CPS over the six-year period. We also recognise that our analysis offers a selected and partial version of events: certain reports and correspondence may have been missing and our analysis is affected by our interpretive frameworks on them.¹¹² However, the sample of seventy-five cases provided enough cases in order to allow a valid analysis of the types of cases the CPS received over this period and allowed an in depth exploration of variance within prosecutorial decision making.

¹¹⁰ See 'No manslaughter charges for misconduct GP Jane Barton', BBC News, 18 August 2010, at <http://www.bbc.co.uk/news/uk-england-hampshire-11008943>; 'Doctor Daniel Ubani unlawfully killed overdose patient', The Guardian, 4 February 2010, at <http://www.guardian.co.uk/society/2010/feb/04/doctor-daniel-ubani-unlawfully-killed-patient>.

¹¹¹ If it is difficult to reconcile the different estimates of MM cases in our study and that of Ferner and McDowell, it is impossible to reconcile either with B. Mitchell and R. McKay, 'Investigating involuntary manslaughter: an empirical study of 127 cases' (2011) 31 OJLS 165. They examined all the involuntary manslaughter cases they could find between 1995 and 2004. Of the 127, only one was clearly GNM.

¹¹² G. Payne and M. Williams 'Generalization in Qualitative Research' (2005) 39 *Sociology* 295.

We undertook a qualitative documentary content analysis of the case files. Using a coding frame, we grouped various features of the cases into categories for comparison (e.g. which test the case fell on and why, what character constructions were made about the victim and defendant). We also performed a more quantitative analysis including categorising the characteristics of victims and defendants, how the case was referred, level of police officer dealing with the case. Again, our aim is not to draw statistically robust conclusions from our data but to explore the decision making process and gain an indication of patterns.

Alongside analysis of CPS case file analysis we conducted semi-structured interviews with CPS casework lawyers in order to address questions that had arisen when analysing particular case files as well as to gain a prosecutors' perspective of the overall process. We spoke to seventeen lawyers of varying experience and position (ten in York and seven in London). These interviews sought to give a deeper understanding of the overall processes involved in decision-making as well as address questions and gaps from within the files.