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Medical manslaughter: where next?

The Williams Review has emphasised the need for a clear and consistent understanding of what constitutes GNM. What does this look like in practice, and what impact will it have?

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The case of Dr Hadiza Bawa-Garba, a paediatric trainee, who was found guilty of gross negligence manslaughter (GNM) following the death of six-year-old Jack Adcock, has alarmed clinicians across the world and left them wondering whether such a fate could befall them.[1] She was erased from the medical register earlier this year after the GMC appealed successfully to the High Court. While there has long been concern about an apparent increase in prosecutions for this crime,[2,3] figures provided by the Crown Prosecution Service to the recent Williams Review remind us how relatively rare they are. Since 2013, while there have been 151 investigations, only 7 were prosecuted (Figure 1). These cases involved a total of 15 healthcare professionals, as listed in Table 1.[4]

Clearly, though, this is seven too many for all those concerned with such tragic cases, and what data are available suggest that inquests and investigations are on an upward trend. A case file analysis in four coroners courts in the North-West of England showed that police investigations and inquests into healthcare deaths had doubled during a 10-year period between 1999 and 2009.[5] With a flurry of recent appeal cases and a further independent GMC-led review under way,[6] we take stock of the evolution of the law as well as the management of these cases, and ask where next for medical manslaughter?

GROSS NEGLIGENCE MANSLAUGHTER – AN OLD PROBLEM?

Cases of so-called medical manslaughter are far from new, with the first reported decision dating back to 1329.[7] The first cluster of cases and the emergence of the concept of 'gross' negligence can be traced to the nineteenth century. The leading authority remains that of *R v Adomako*, where Lord Mackay explained that gross negligence 'will depend on the seriousness of the breach of duty committed by the defendant in all the circumstances in which the defendant was placed … [and] the extent to which the defendant's conduct departed from the proper standard of care incumbent upon him, involving as it must have done a risk of death to the patient, was such that it should be judged criminal.'[8] This formulation has been criticised for its circularity and lack of certainty and has undoubtedly been challenging to interpret and apply.[9,10] Four Appeal Court decisions in five years is testament to this.[11–14]

The result of this recent attention on gross negligence, much of it by the same judge, Sir Brian Leveson, has been a tightening of the law. In particular, the successful appeals of David Sellu, a consultant colorectal surgeon, and Honey Rose, an optometrist, appear to have raised the bar of liability in two ways.

First is the description of gross negligence as 'truly exceptionally bad' and 'reprehensible' conduct. Judges have long used a variety of terms to capture the grossness of the negligence, even referring to the higher form of criminal fault known as recklessness.[5,9] Directing juries of the need for exceptionally bad and reprehensible conduct[5,9] appears to underline that gross negligence is a very high threshold.

Second, there has been a narrowing of the requirement for assessing the risk of death associated with the gross negligence. In the cases of Rudling and Rose, Sir Brian Leveson has required that it was 'reasonably foreseeable that the breach gave rise to a serious and obvious risk of death'. The application of this in the case of Rose is controversial in that it undermines the objective basis of this form

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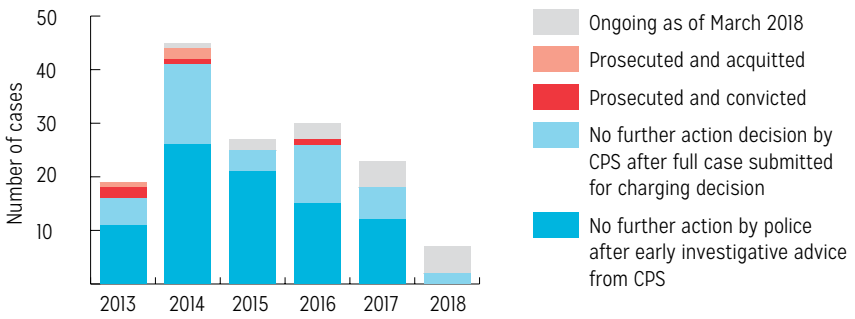
of criminal fault – the idea that the defendant is to be judged against the standards of care expected of the so-called reasonable practitioner, not someone with the defendant's shortcomings of failing to properly conduct an eye examination.[15] We suspect this will not be the last judicial word on this issue and that the test will be refined in future cases. But for now, and coupled with the judicial direction on gross negligence, the combined effect is to make convictions (and perhaps prosecutions) less likely. But what else can be done to improve the management of these cases in the justice system?

WILLIAMS REVIEW RECOMMENDATIONS

In February 2018, Jeremy Hunt, Secretary of State for Health and Social Care, asked Professor Sir Norman Williams to lead a review of GNM in healthcare, given concern that it is creating a negative 'just learning culture'. The central recommendation in the report is the need for an agreed, clear and consistent understanding on the law of gross negligence manslaughter. Alongside this it calls for a new memorandum of understanding between the Crown Prosecution Service (CPS), police, coroners, the Care Quality Commission, Health and Safety Executive, the Healthcare Safety Investigation Branch and professional regulators for investigating healthcare-related deaths.[4] While a clear and shared understanding of gross negligence is desirable, does this also require further attempts to specify more precisely what is meant by gross negligence? One possibility sure to be discussed is the creation of a specific policy for GNM setting out all relevant factors in favour or against prosecution, as exists for the offence of encouraging or assisting suicide.[16]

The creation of a 'virtual specialist unit' of expertise for the police, also recommended by Williams, might help ensure that only the strongest cases are investigated. As might the recommendation for updated coronial guidance. More controversially it recommends that the GMC should lose its right to appeal to the high court against decisions of the Medical Professionals Tribunal Service

Figure 1 CPS Special Crime unit gross negligence manslaughter cases (January 2013 to March 2018) – Breakdown by referral year[4]



(MPTS). The MPTS had rejected erasure in the case of Dr Bawa-Garba. The Professional Standards Authority (PSA), which oversees all the professional regulators, including the GMC, will retain its separate right to appeal if it thinks that an MPTS decision on a doctor's fitness to practise is wrong. This should be reassuring to bereaved families, as should the new network of medical examiners that is being established to look at all patient deaths in NHS hospitals that aren't referred to a coroner.[4] Williams also recommended that objective, early expert witness opinion should be obtained from experts working in relevant, current clinical practice and within a framework of good practice for doctors providing medico-legal opinions. The Academy of Royal Medical Colleges (AORMC) has been tasked with defining the standards expected of expert witnesses and setting out principles of good practice.

Doctors in training to become consultants are required to keep notes, known as 'reflections', in which they are candid about their own performance. Such notes are not legally privileged and so may be admissible in legal proceedings. In its evidence to the Williams Review, the CPS advised that such material is unlikely to be used in prosecutions but that this remains a possibility if that evidence is considered material to a case. While the GMC does not routinely request reflective material for its hearings, all evidence is potentially disclosable in a criminal case. Guidelines have been issued by the AOMRC on reflection but these have not completely reassured an anxious profession.[17]

Interestingly, in New Zealand there is limited legislative protection for reflective notes and reflective parts of clinical training programmes.[18] The information protected cannot be revealed beyond the process for which it was intended (namely training and CPD). However, this protection is unlikely to mean that the material is absolutely beyond the reach of the criminal court.[19] Most, if not all, doctors would support any commitment by the AOMRC to work towards this as it is fundamentally a patient safety issue.

HOW SHOULD WE DEAL WITH MEDICAL ERRORS?

The use of homicide law for responding to fatal medical error has always been controversial, not only because of its potential harshness, but also due to the vague test of liability. However, we do not agree that this part of English common law is in some way inferior to that of other jurisdictions. This area has actually evolved considerably through recent events and greater clarity is now available for prospective defendants, which should provide reassurance. While preventable patient deaths clearly demand a response, there are concerns that criminal investigations may impact negatively on efforts to create a culture of safety in healthcare. Many medical professionals are concerned that the adversarial nature of the criminal court may not allow a lay jury to weigh appropriately the individual, team and systemic contributions to a complex medical death.[20]

The recent publishing of definitive sentencing guidelines for manslaughter has shown a constructive approach. This document will be used by judges in sentencing those convicted (including any future healthcare workers convicted of GNM while performing their duties). Collective work by a range of medical organisations has meant that judges must consider a range of mitigating factors that are not healthcare-specific but are highly relevant. Examples include whether the negligent conduct was compounded by the actions or omissions of others beyond the offender's control. In addition, if the offender was subject to stress or pressure (including from competing or complex demands) which related to and contributed to the negligent conduct, this would be considered.[21]

The outcome of Dr Bawa-Garba's recent appeal against her erasure is awaited. Was the GMC right to appeal the verdict of the Medical Practitioner's Tribunal Service (MPTS) in the light of the jury finding that her errors were 'truly, exceptionally bad' in the care of Jack Adcock? Many healthcare professionals simply don't agree given the compromised system in which she was working that day. Her QC Mr James Laddie told the Court of Appeal that it was in fact the MPTS's decision that was 'humane and balanced'. The British Medical Association (BMA), the British Association of Physicians of Indian Origin (BAPIO) and the PSA applied as intervenors in the appeal. The PSA asserted that it is 'deep-seated attitudinal problems' that are typically a good reason for deciding that a clinician should be prevented from practising. It is common ground that she had an unblemished career both before and after Jack's death. Bawa-Garba also gave a statement after the hearing whole-heartedly apologising again to the family of Jack Adcock for her part in his death.[22]

Whether the recent initiatives outlined here will mean that in future healthcare workers making honest errors are less likely to end up facing criminal investigation remains to be seen. Only performance that is 'truly, exceptionally bad' should lead to criminal investigation, and the prosecution must take proper account of all the systemic errors, including those that hospitals might identify

Table 1 Healthcare professionals charged with manslaughter by gross negligence January 2013 to March 2018

	Deceased	Accused	Profession	Alleged gross negligence	Charged (or first court appearance)	Outcome
1	Vincent Barker	Honey Rose	Optometrist	Missed papilloedema	2015-09-08	Convicted August 2016 but overturned on appeal
2	Frances Cappucini	Dr Errol Cornish	Anaesthetist	Suffered a haemorrhage after emergency caesarean section	2015-05-08	Not Guilty, judge directed acquittal
3	"	Dr Nadeem Azeez	Anaesthetist	"	(Arrest warrant issued)	Fled the country
4	Jack Adcock (Mount)	Dr Bawa-Garba	ST6 paediatrics	Missed sepsis	2014-12-17	Convicted 2015-11-04
5	"	Theresa Taylor	Sister	"	2014-12-17	Acquitted 2015-11-04
6	"	Isabel Amaro	Staff Nurse	"	2014-12-17	Convicted 2015-11-02
7	Phoebe Willis	Carrie-Anne Nash	Nutrition nurse	Feeding tube –> peritonitis	2015-09-18	Acquitted
8	Aisha Chithira	Dr Adedayo Adedeji	Doctor	Operative error during termination; haemorrhage	2015-06-19	Case withdrawn lack of evidence day 1 of trial
9	"	Gemma Pullen	Nurse	"	2015-06-19	"
10	"	Margaret Miller	Nurse	"	2015-06-19	"
11	Ali Huseyin	Lea Ledesma		Incorrect blood type transfusion	Charges 2015, 1st trial 2016, Re-trial 2016	Convicted 12-2016
12	James Hughes	David Sellu	Surgeon	Surgical delay	2 October 2013	Convicted 5 November 2013 but overturned on appeal
13	Ryan Morse	Joanna Rudling	GP	Failure to manage deteriorating patient	4 May 2016	Not Guilty, judge directed acquittal 27 May 2016
14	"	Lindsey Thomas	GP	"	"	Not Guilty, judge directed acquittal 17 May 2016
15	Joshua Gafney	Amanda Young	Nurse	Drug overdose	26 May 2015	15 June 2015

after tragic deaths which might have played a part. The Marx review (now chaired by Leslie Hamilton and renamed the Independent Review of Gross Negligence Manslaughter and Culpable Homicide)[23] is in the final phase of taking written submissions. A series of workshops will be run in the autumn and it is hoped that its conclusions will further assist in this most difficult of areas.[6] Further insights and recommendations will follow from new empirical research about the management of such cases in the justice system.[24,25] Crucially, the role of all parties in any medical death where criminal charges have been made should be carefully clarified so that the jury is able clearly to understand their responsibilities. Enhanced protection of clinical reflections should be further examined by the UK's medical royal colleges in a timely fashion. As a society we must ensure the criminal justice system deals with medical errors in a way that does not compromise patient safety or fairness to all those involved.

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Editor's note: At the time of going to press of this article, the outcome of Dr Bawa-Garba's appeal was not yet known.