GROSS NEGLIGENCE MANSLAUGHTER: A POORLY PRINCIPLED CRIME

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CONTENTS

1. ABSTRACT

Doctors who negligently kill their patients run a small risk of a criminal conviction for gross negligence manslaughter. The ethical basis of the crime is unsound and the legal mechanics by which convictions are brought is faulty. Doctors who display culpable attitudes should be subject to criminal sanction if their behaviour results in harm to their patients; they should not have to first kill their patients before being arrested. To this extent the offence also lacks sufficient scope. On the other hand, provided the doctor lacks the necessary *mens rea*, he should not face conviction whatever the harm he has caused. Regulatory bodies must be made to regulate more effectively and expert witness testimony should be subject to much greater scrutiny both before being admitted and weighed by judge and jury. Employing Trusts too have a part to play in making their working environments more hostile to both the reckless and the feckless.

2. INTRODUCTION

Criminal law exists to allow the State to press its moral authority on its citizens. By using punishment the State aims to provide a stick with which to correct transgression for the benefit of society as a whole. Tort law exists to remedy the individual who has been wronged by another individual. Both routes to justice provide different measures of punishment, public protection, deterrence, reparation and rehabilitation. Manslaughter sits firmly within the criminal sphere of justice whereas negligence has its roots within tort and the civil courts.[1] Bringing the two together in English law has been a difficult task not least because of the different terms of reference used by each of the two legal frameworks.

The author, a practising anaesthetist, will attempt to make sense of the law as it stands and aim to demonstrate by legal argument that clinical gross negligence manslaughter is poorly principled, highly subjective and serves little purpose. A charge of reckless manslaughter may be suitable for the individual doctor but regulatory bodies, the Health and Safety at Work Act 1974 and Corporate Manslaughter and Corporate Homicide Act 2007 should have a greater role in public protection. Wherever a doctor or Trust has been found to be merely feckless rather than reckless, a negligence action through the civil court will deal with compensation; professional regulators, such as the General Medical Council and Care Quality Commission should be responsible for correcting the doctor or the Trust.

The mechanics of prosecuting the offence is also found to be faulty. Many cases are screened from the courts by a Crown Prosecution Service whose terms of reference are not fully aligned with modern common law. Once in court, the testimony of expert witnesses leaves much to be desired both in terms of the admissibility of evidence and the weight attached to it.

Hence, the process of criminalising medical negligence falters on legal principle and displays procedural inconsistency. Taken together, faulty principle and procedure result in the incarceration of just a few unlucky incompetents whilst leaving sometimes more dangerous individuals free to continue causing harm. The broader context of the crime (be that manslaughter or breaches in health and safety regulation) is not the focus of an adversarial criminal trial; regulatory failures or working environment problems which have contributed to

[1] Broadly speaking manslaughter relates to an unlawful killing in which the defendant did not intend to bring about death. This is discussed in detail in Ashworth & Horder, *Principles of Criminal* Law' (7th edition, Oxford 2013) 276–306 and Law Commission, *Legislating the Criminal Code: Involuntary Manslaughter* (Law Com No 237, 1996)

the crime may be mitigating factors for the individual practitioner but themselves are not subject to robust censure. On the other hand, recklessness, causing harm but not death, is not represented at a criminal level; an anomaly which will be examined.

Using key cases to highlight the above it will be shown that culpability (*mens rea*) is the proper test of criminality and singling out an individual as the final common pathway in what is usually a whole sequence of acts and omissions provides punishment but very little deterrence or public protection. Reference is made to how the focus and scope of the crime could be improved to make the offence more palatable to the public, judiciary and doctors.

3. CRIME AND TORT

Simple negligence moves from tort to crime when the negligence both causes death and is considered to be gross. In order to make sense of this pivotal change in direction we need to examine what constitutes a crime.

3.1 Crime

Section 26 of the Road Traffic Act 1988 prohibits cyclists from holding onto slow moving farm vehicles in order to get a pull up a hill. Murder is prohibited by common law. Both are crimes against the State. The obvious difference is that of magnitude and this is reflected not only in the punishment for each crime but also the way in which the law deals with them. The lesser crime is essentially regulatory and requires only that the offence occurred (*actus reus*); no proof of intent is required (*mens rea*). Regulatory offences stem from the numerous Factory Acts of the 19th Century which were passed in order to improve the safety of factory workers without needing to prove the 'guilty mind' of the factory owners. The punishment meted out against those guilty of regulatory offences (quasi-crimes) is necessarily minimal and usually expressed as a fine. The efficiency of public protection afforded by dispensing with the need for *mens rea* is deemed by the State to be a price worth paying. Murder on the other hand carries a serious penalty and quite reasonably the defendant deserves procedural protection. The State cannot simply imprison people for minor transgressions simply because it is a more efficient than following due process.[2]

Regulatory offences are often ones of strict liability for the purposes of practicality as much as anything else. In this sense they offer protection to the public before a more serious offence actually occurs.

Planning to explode a bomb on an aeroplane is an example of an inchoate crime.[3] Until the bomb actually explodes and kills tens of people it is harmless in itself; it is rather like tractor trailer holding on a grand scale. The major difference, apart from scale, is one of intent. Planning to bomb a plane must involve a criminal mind and to protect the public from would-be bombers it is a serious criminal offence. There is a stiff penalty and so to protect the defendant proper procedures deserve to be followed. It is not enough to find bomb making

[2] *Benham v UK* [1996] 22 ECHRR 293

[3] Terrorism Prevention and Investigation Measures Act 2011, s 4

equipment, communication and plans (even if quite obviously the work of the defendant) in order to secure conviction. It cannot be a strict liability offence; *mens rea* must be evident.[4]

The presumption of *mens rea* is a constitutional principle extolled in numerous cases. Most famously in *Sweet v Parsley* Lord Reid said

> [T]here has for centuries been a presumption that Parliament did not intend to make criminals of persons who were in no way blameworthy in what they did. That means that whenever a section is silent as to *mens rea* there is a presumption that, in order to give effect to the will of Parliament, we must read in words appropriate to require *mens rea*.[5]

These sentiments were echoed by in Lord Nicholls in *B v DPP;*

> [T]he starting-point for a court is the established common law presumption that a mental element, traditionally labelled *mens rea*, is an essential ingredient unless Parliament has indicated a contrary intention either expressly or by necessary implication. [6]

and by Lords Bingham and Steyn in *R v K*.[7] [8]

By contrast, the same cases brought to light significant exceptions to the presumption of *mens rea*. In *Sweet* both Lords Reid and Diplock made exceptions:

> …[i]t is firmly established by a host of authorities that *mens rea* is an essential ingredient of every offence unless some reason can be found for holding that that is not necessary. [9]

> But where the subject matter of a statute is the regulation of a particular activity involving potential danger to public health, safety or morals..., the court may feel driven to infer an intention of Parliament to impose by penal sanctions a higher duty of care on those who choose to participate and to place upon them an obligation to take whatever measures may be necessary to prevent the prohibited act, ... in order to fulfil the ordinary common law duty of care. But such an inference is not lightly to be drawn, nor is there any room for it unless there is something that the person ... may be expected to influence or control, which will promote the observance of the obligation.[10]

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[4] '[I]n general a person does not incur criminal liability unless he had the requisite state of mind [*mens rea*] as to those elements which constitute the crime. These concepts are traditionally expressed in the maxim '*actus non facit reum nisi mens sit rea*'' which, translated means "an act does not make a person guilty unless (their) mind is also guilty". From *Halsbury's Laws of England*: *Criminal law* (5th edition, 2010) vol 25, para 4

[5] *Sweet v Parsley* [1970] AC 132 (HL) 148

[6] *B v DPP* [2000] 2 AC 428 (HL) 460

[7] *R v K* [2001] UKHL 41, [2002] 1 AC 462, 472-473 (Lord Bingham)

[8] *R v K* [2001] UKHL 41, [2002] 1 AC 462, 478 (Lord Steyn)

[9] *Sweet v Parsley* [1970] AC 132 (HL) 149 (Lord Reid)

[10] *Sweet v Parsley* [1970] AC 132 (HL) 163 (Lord Diplock)

Giving the judgment of the Privy Council in *Gammon*, Lord Scarman said

> [T]he presumption of *mens rea* stands unless it can also be shown that the creation of strict liability will be effective to promote the objects of the statute by encouraging greater vigilance to prevent the commission of the prohibited act.[11]

More recently Baroness Hale implied that allowing the defence of a reasonable mistake (negligence) would reduce public protection unacceptably.[12] Whilst the strict liability she was referring to related to the Sexual Offences Act 2003, the principle that public protection might outweigh the unfairness and stigma of convicting the defendant is clearly implied.

Ashworth states that 'no person should be liable to imprisonment without proof of sufficient fault' and berates the judgment in *Gammon* as it argues for the imposition of strict liability for more serious offences, including those resulting in imprisonment.[13]

Lamond takes much the same view in his paper 'what is crime?'

> The practice of folding strict liability offences into the ambit of the criminal law diminishes the doctrinal purity of the latter and dilutes its expressive role in social life. More particularly, the failure to draw a systematic distinction between fault-based crimes and strict liability offences creates confusion over the proper basis for punishment, as it erases the important distinction between penalties and punishments.[14]

As alluded to, *mens rea*, a 'criminal mind', creates the moral basis for culpability in all crimes other than the regulatory offences described earlier. As we move from harm caused by intent, recklessness, gross negligence and 'simple' negligence there is a corresponding drop in blameworthiness or culpability; those causing deliberate harm are clearly more deserving of society's condemnation than those who mean to do good but cause harm through sheer bad luck. The caveat to this, as described in *Sweet*, is that punishment may not be proportionate to the level of individual culpability if there is an over-riding need to set an example.

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[11] *Gammon v Attorney General for Hong Kong* [1984] 2 All ER 503 (HL) 509

[12] *R v G* [2008] UKHL 37, [2008] All ER (D) 216 (Jun)

[13] Ashworth & Horder, *Principles of Criminal Law* (7th edition, Oxford 2013) 168

[14] Grant Lamond, 'What is a Crime?' [2007] 27 Oxford Journal of Legal Studies 609

3.2 Tort

The tort of negligence rests on proving that, on the balance of probabilities, harm was caused to the claimant by the defendant.[15] The defendant owed a duty of care to the defendant, there was a breach of this duty, the breach caused the harm and the harm was foreseeable. Despite small modifications over the years, this tort is fairly settled, at least in principle. In medical negligence, medical experts are called to argue whether the defendant was actually in breach of his duty since there can be reasonable variations on how a professional will correctly handle a particular clinical problem.[16] There are also issues regarding causation since it is not always clear that the harm in question was caused by the breach of duty. Nevertheless, the tetrad of duty, breach, causation and foreseeability is trite law.

Manslaughter is unintended homicide.[17] It is a criminal offence, the punishment for which depends on the degree of culpability and the ebb and flow of parliamentary opinion.[18] A death which is intended is murder but this is probably unusual in medical settings.[19]

At one extreme we have a defendant deliberately harming a victim but only intending to cause serious harm, not death.[20] The level of culpability here is clearly high. At the other extreme we have a doctor attempting to help his patient but inadvertently causing their death through negligence.[21] Herein lies the problem and the essence of this essay; is it just to convict as a criminal a doctor who, through negligence, causes the death of their patient? Is the criminal bar for harm set at the same level that culpability comfortably sits? Put another way, are culpable, harm causing doctors escaping criminal justice or are well meaning doctors being convicted for harm caused without *mens rea*?

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[15] *Donoghue v Stephenson* [1932] UKHL 100

[16] *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 (QB) and *Bolitho v City and Hackney Health Authority* [1997] 4 All ER 771 (CA)

[17] This is discussed in detail in Ashworth & Horder, *Principles of Criminal* Law' (7th edition, Oxford 2013) 276–306 and Law Commission, *Legislating the Criminal Code: Involuntary Manslaughter* (Law Com No 237, 1996)

[18] The minimum term for murder was raised by the Criminal Justice Act 2003 and the Court of Appeal in *R v Garg* [2012] EWCA Crim 2520, [2013] 2 Cr App R (S) 30 Crim held that sentences for all types of manslaughter should be punished more severely. See also Hannah Quirk **'**Sentencing white coat crime: the need for guidance in medical manslaughter cases' [2013] Criminal Law Review 871

[19] Harold Shipman being a notable and prolific exception.

[20] *R v Nedrick* [1986] 83 Cr App R 267 (CA)

[21] *R v Prentice and another; R v Adomako; R v Holloway* [1993] 4 All ER 935 (CA)

An examination of what is meant by *mens rea* and the way in which different judges over time have dealt with doctors causing death goes to the heart of why medical gross negligence manslaughter is such an ethically difficult offence to justify.

4. *MENS REA* AND CULPABILITY

On the one hand we have the situation as existed in New Zealand for some years; death caused through negligence equated to gross negligence manslaughter and was punishable in a criminal court.[22] On the other hand we could postulate a situation whereby a doctor could cause the death of his patient by attempting a surgical procedure he was totally incapable of performing from the outset, in the full knowledge that the outcome was likely to be an avoidable death. Inadvertent death at the hands of a well meaning but unfortunate clinician versus death at the hands of a thoroughly reckless individual. Does the former merit a criminal trial? Should all cases of death by negligence be tested in a criminal court and the level of culpability settled in sentencing?

Currently, in English law, negligence is only considered as possibly criminal if it causes death. We shall look at this anomaly later. For now we will review some of the key cases defining gross negligence manslaughter as a crime and then comment on the legal rationale for apportioning blame.

4.1 *Bateman* – a disregard for the life and safety of others

In 1924 Dr Bateman attended the home of Mary Harding who was in labour. The unborn child was malpositioned and would require medical input in order to be safely delivered. Dr Bateman attempted delivery with forceps and then, having failed, tried to turn the child manually to effect a more favourable presentation. In the end the child was still born and the mother left with a number of internal injuries because of the cephaloversion.[23] In addition, her uterus was severely damaged and delivered along with the placenta. Dr Bateman thereafter visited Mary twice daily but did not refer her to hospital for several days by which time she was beyond surgical help; he claimed he thought she was going to die anyway. The judge in the court of first instance grouped together i) the internal injuries resulting from the cephaloversion, ii) the removal of the bulk of the uterus along with the placenta and iii) failure to make a timely referral. He directed the jury to find Dr Bateman guilty of gross negligence manslaughter if they found he had been negligent on any of the three points.[24] The Court of Appeal judged this to be an incorrect direction to the jury. In addition there was

[22] The Crimes Act (New Zealand) 1961 effectively made death due to negligence a criminal offence. This remained the case until the Crimes Amendment Act (New Zealand) 1997 which required a greater degree of culpability to be evident before conviction.

[23] See **Glossary**

[24] *R v Bateman* [1925] All ER Rep 45 (CA)

insufficient evidence that the cephaloversion was performed negligently and strong defence evidence of the futility of moving the patient to the infirmary earlier. The severe uterine damage may well have been caused negligently (albeit inadvertently). The conviction for manslaughter was quashed and in making his judgment Lord Hewart CJ made some notable points:

> In the civil action, if it is proved that A fell short of the standard of reasonable care required by law, it matters not how far he fell short of that standard. The extent of his liability depends not on the degree of negligence, but on the amount of damage done. In the criminal court, on the contrary, the amount and degree of negligence are the determining question. There must be *mens rea*.[25]

This suggests that if the family of the deceased wished to pursue a civil negligence claim against Dr Bateman for the severe uterine damage suffered by Mary Harding resulting in her death, they may have been successful. However, if the Crown wanted to convict Dr Bateman of manslaughter:

> [T]he prosecution must prove the matters necessary to establish civil liability and...must satisfy the jury that the negligence or incompetence of the accused went beyond a mere matter of compensation and showed such disregard for the life and safety of others as to amount to a crime against the State and conduct deserving punishment.[26]

Even by the standards of the day Dr Bateman was probably negligent and his negligence at least contributed to a death but since Lord Hewart considered Bateman's actions well-meaning he lacked the 'criminal mind' required to secure conviction. For Lord Hewart, *mens rea* was a vital ingredient.

4.2 *Yogasakaran* – negligence is criminal if death ensues

If we move forward to *Yogasakaran* the concept of *mens rea* as a vital criminal ingredient disappears entirely.[27] Dr Yogasakaran was an anaesthetist working in New Zealand when he made an honest mistake that led to the death of his patient.

At the end of routine gall bladder surgery a patient bit down on their breathing tube and effectively cut off their own oxygen supply. This is not unusual and many anaesthetists will insert a bite block to prevent this from happening. Other anaesthetists will simply wait until the biting stops and then remove the tube. Occasionally the patient will bite so hard and for so long that the tube becomes occluded and they begin to turn blue. Dr Yogasakaran's patient did just this so he quite reasonably decided to administer doxapram to hasten

[25] *R v Bateman* [1925] All ER Rep 45 (CA) 47

[26] *R v Bateman* [1925] All ER Rep 45 (CA) 47

[27] *R v Yogasakaran* [1990] 1 NZLR 399

emergence from anaesthesia (and thus terminate the biting). Unfortunately, the ampoule he opened and administered in haste was dopamine and not doxapram. The two had been erroneously put together in the same container by someone else. The dopamine had serious cardiovascular consequences and the patient was transferred to the intensive care unit for further care. Dr Yogasakaran couldn't explain what had happened to the patient on the basis of doxapram administration and so he examined the opened ampoules and volunteered the error he had made to the receiving intensive care team. Unfortunately, the patient had sustained fatal physiological stresses and died shortly later. Dr Yogasakaran's honest mistake cost a patient their life and resulted in his criminal conviction. What would Lord Hewart have made of this if he felt Dr Bateman was unfairly punished?

In *Bateman* and *Yogasakaran* we have two quite opposing views of what constitutes a crime; the former requiring *mens rea* and the latter requiring only simple negligence for the court to bring a conviction of manslaughter. Any doctor guilty of negligence by civil standards will automatically be guilty of manslaughter if the result of the negligence is death if *Yogasakaran* is followed.

4.3 Feckless or reckless?

Predictably, there have been cases where a middle ground has been trodden by judges. Most judges appear to make a distinction between ignorance and conscious unjustifiable risk-taking; for the sake of this section, fecklessness and recklessness.[28] Take, for instance, Lord Atkin in *Andrews*. He took the view that there are degrees of negligence and 'a very high degree of negligence is required to be proved before a felony is established'. The term 'reckless' was seen to 'nearly cover the case'. However, he went on to say '"reckless" suggests an indifference to risk, whereas the accused may have appreciated the risk, and intended to avoid it, and yet shown in the means adopted to avoid the risk such a high degree of negligence as would justify conviction'.[29]

Whilst Lord Atkin said he 'did not find...the connotations of *mens rea* helpful in distinguishing between degrees of negligence' it is contended that he did for the former part of his summary. He ignores *mens rea* only in his last few words 'the means adopted to avoid the risk [show] such a high degree of negligence as would justify conviction'. Essentially he is saying that a crime is committed either through recklessness or a high degree of negligence.

[28] Feckless in the sense of 'feeble, ineffectual, helpless' as per *Chambers Dictionary* (9th Edition, 2003). The feckless doctor should do better and should know better but without malice or evil intent has presided over a fatally negligent act or omission.

[29] *Andrews v DPP* [1937] 2 All ER 552 (HL) 556

This position was taken over 200 years ago in *Williamson* and *Long.*[30] [31] Here, criminal inattention is on the same footing as gross ignorance; the ignorance manifested by the feckless and the deliberate actions of the reckless occupy the same criminal stage.

"Recklessness" implies unreasonable risk taking; a conscious decision to ignore the possibility of a bad outcome or, as Lane LJ put it, 'indifference to an obvious risk and appreciation of such a risk, coupled with a determination nevertheless to run it, are both examples of recklessness'. Furthermore, echoing *Bateman* and *Andrews*, Lane LJ went on to say 'mere inadvertence is not enough'. [32]

Lord Atkin's "reckless" position in *Andrews* suggests that recklessness renders a defendant culpable. We will look carefully at recklessness since it forms a proper basis for culpability.

If a competent surgeon were to leave her patient bleeding internally because she couldn't be bothered to spend the time cauterising blood vessels and the patient subsequently died she would be culpable and guilty of manslaughter due to advertant recklessness. However, Lord Atkin's "high degree of negligence" addendum suggests that an incompetent surgeon doing the same operation could be found guilty of the same offence simply by being unaware that the bleeding needed to be stopped or by being unable to use the cautery machine. On the face of it, the former surgeon is reckless and the latter simply feckless. The end result is the same; neither should be operating on patients but is argued that whilst the former is clearly culpable the same degree of culpability may not exist for the apparently feckless surgeon. The feckless surgeon might be more of a menace to the public and in greater need of removal from the operating room but is criminal punishment the correct course of action?

Can we legitimately argue gross ignorance and criminal inattention are equally culpable and, therefore, criminal?

[30] *R v Williamson* [1807] 3 C and P 635 'to substantiate the charge of manslaughter the [defendant] must have been guilty of criminal misconduct arising either from the grossest ignorance or the most criminal inattention'

[31] *R v Long* [1831] 4 C and P 423 '...a medical man is not criminally responsible for the death of a patient....unless his conduct is characterised either by gross ignorance of his art or gross inattention to his patient's safety.'

[32] *R v Stone, R v Dobinson* [1977] 2 All ER 341 (CA) 345-347

The leading case on medical gross negligence manslaughter remains *Adomako* which we will examine.

4.4 *Adomako* - gross ignorance and criminal inattention are culpable

Dr Adomako was a locum anaesthetist who had been working at the Mayday hospital during the weekend of the death of Mr Loveland during an emergency eye operation. Having not taken to bed until 3.30 am Dr Adomako was back on the wards at 07.00 am and took over the anaesthetic care of Mr Loveland at 10.35 from Dr Said who had cannulated, induced, and paralysed Mr Loveland some time earlier that morning.[33] [34] At about 11.05 the ventilator tubing became disconnected near the mouth of Mr Loveland and, being medically paralysed, he was unable to breath. This went undiagnosed by Dr Adomako until far too late by which time Mr Loveland had suffered a fatal cardiac arrest.[35] Dr Adomako did realise that something was wrong but made the erroneous diagnosis of oculo-cardiac reflex which he correctly treated, not appreciating the evidence of ventilator disconnection his clinical skills and monitoring should have alerted him to.[36]

The appeal court in *Adomako* analysed *Andrews*, *Bateman* and *Yogasakaran* (amongst many others) and decided where to place the criminal bar.[37] They did not like the term "reckless", preferring "gross negligence" as the test of criminality.[38] The ingredients of involuntary manslaughter by breach of duty were deemed to be proof of a breach in a duty owed by the defendant by means of gross negligence (justifying a criminal conviction). Helpfully, gross negligence, the crux of the matter, was defined as proof of any of the following states of mind:

a) indifference to an obvious risk of injury to health;
b) actual foresight of the risk coupled with a determination nevertheless to run it;
c) an appreciation of the risk coupled with an intention to avoid it but also coupled with such a high degree of negligence in the attempted avoidance as the jury consider justifies conviction;

[33] *R v Prentice and another; R v Adomako; R v Holloway* [1993] 4 All ER 935 (CA) 951

[34] This is the normal sequence of events for an anaesthetic of this sort (see also **glossary**)

[35] *R v Prentice and another; R v Adomako; R v Holloway* [1993] 4 All ER 935 (CA) 952

[36] *R v Prentice and another; R v Adomako; R v Holloway* [1993] 4 All ER 935 (CA) 953

[37] *R v Prentice and another; R v Adomako; R v Holloway* [1993] 4 All ER 935 (CA)

[38] The references to 'reckless' made during the other two cases heard alongside Adomako were successfully appealed because the jury should have been directed to consider 'gross negligence' instead of 'recklessness'.

d) inattention or failure to avert to a serious risk which goes beyond 'mere inadvertence' in respect of an obvious and important matter which the defendants duty demanded he should address.[39]

It is argued that a) describes a morally culpable disregard for another's well-being, b) is effectively a definition of advertent recklessness (requiring *mens rea*), c) is well-meaning incompetence or fecklessness (requiring ignorance, stupidity or clumsiness but little, if any, *mens rea*) and d) is an example of negligence.

Dr Adomako's case was considered in the House of Lords who agreed that gross negligence was the correct test to have used.[40] Unhelpfully, there was little comment on what turned mere negligence into gross negligence. Lord Mackay said:

> This will depend on the seriousness of the breach of duty committed by the defendant in all the circumstances in which the defendant was placed when it occurred. The jury will have to consider whether 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.[41]

This doesn't seem a long way further forward than *Andrews* in terms of clarity and focus. A doctor can be convicted of manslaughter if either recklessly causing death or by simply being a well meaning incompetent. It is left to the jury, guided by adversarial Crown and defence expert witnesses, to decide on what constitutes gross negligence as opposed to simple negligence; crime against the state or compensation between individuals.[42]

Removing from service both culpably reckless and fatally clumsy doctors with the broad sword of criminal conviction, on the face of it, provides a public service. Is there any need to worry about the means if the end result provides public protection?

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[39] *R v Prentice and another; R v Adomako; R v Holloway* [1993] 4 All ER 935 (CA) 944

[40] *R v Adomako* [1995] 1 AC 171 (HL)

[41] *R v Adomako* [1995] 1 AC 171 (HL) 187

[42] '[W]hat turns mere (civil) negligence into gross (criminal) negligence is the size of the gap between the standard of care actually shown by the defendant and what could reasonably have been expected. Only if the gap is big enough - and that is a matter for the jury or bench of magistrates to determine without any assistance from the law - will the negligence be gross.' Barry Mitchell 'Being really stupid: the meaning and place of gross negligence in English criminal law' [2002] Coventry Law Journal 12,15

4.5 Recklessness

As argued earlier, in *Adomako*, recklessness effectively formed two of the four tests of gross negligence.[43] Whilst he was found guilty of gross negligence, the word reckless has been applied as an epithet to help juries understand what is being asked of them in preceding cases of gross negligence manslaughter.[44] Indeed, McCall Smith argues that there is widespread judicial misunderstanding of the difference between negligence and recklessness.[45] The lack of judicial understanding of the important differences between the two 'is not grounds for the abandonment of a distinction which is of considerable moral weight'.[46] For this reason it is important to examine the culpable states of mind found in cases of recklessness, particularly if we are arguing that reckless should be reinstated as the test of criminality.

Several definitions of recklessness have existed depending on the context. This obviously causes problems, not least for jurors who may be confused as to why there is not one legal definition. At its heart 'advertent recklessness' means the defendant can see that his actions run the risk of causing harm but he goes on to take the risk anyway. This followed the judgment in *Cunningham* and was central to the Criminal Damage Act.[47] [48] This so-called subjective test left a potential gap through which culpable defendants could escape justice; if the defendant cannot be shown to have known about the risks, whatever harm he causes he cannot be convicted of recklessness. To plug this uncomfortable gap *Parker* extended the *Cunningham* definition of recklessness to cover those defendants who 'closed their minds' to the obvious risks they were taking.[49] Effectively, to 'close one's mind' is a deliberate act to either ignore or discount obvious risks and was considered culpable in itself. This still left open the possibility of someone causing damage simply by not thinking at all. Lord Diplock

[43] 'a) indifference to an obvious risk of injury to health; b) actual foresight of the risk coupled with a determination nevertheless to run it.' *R v Prentice and another; R v Adomako; R v Holloway* [1993] 4 All ER 935 (CA) 944

[44] *Andrews v DPP* [1937] 2 All ER 552 (HL)

[45] Alexander McCall Smith 'Criminal negligence and the incompetent doctor' [1993] 1 Medical Law Review 336 [339]

[46] Alexander McCall Smith 'Criminal negligence and the incompetent doctor' [1993] 1 Medical Law Review 336 [339]

[47] *R v Cunningham* [1957] 2 QB 396 (CA)

[48] Criminal Damage Act 1971

[49] *R v Parker* [1977] 2 All ER 37 (CA)

in *Caldwell* dealt with this anomaly by invoking the 'ordinary prudent individual' test akin to his ordinary prudent motorist standard espoused in *Lawrence*.[50]

One of the problems with expanding a definition is to encompass acts which should not attract criminal sanction. These false positives replace the false negatives created by too narrow a definition. Lord Diplock's approach left no room for those who can never be an ordinary prudent individual; the mentally challenged or immature. *Elliot v C* highlighted the unfairness of this approach but it wasn't until *R v G* that the nettle was firmly grasped and Lord Diplock's much criticised speech put into context.[51] [52] The two individuals convicted of recklessness did not have the mental capacity to form the *mens rea* required to justify their conviction. Hence, the Lords, in the interests of justice, departed from *Caldwell*, but only in so much that mental capacity must be considered in recklessness cases. Nevertheless, a degree of subjectivity was restored.

4.5.1 Advertent and inadvertent recklessness

Despite the demise of *Caldwell* the case deserves attention at this stage not least because of the arguments it generated by implying the equal culpability of advertent and inadvertent recklessness.[53] Lord Bingham expressed his unease at this suggestion by saying:

> It is clearly blameworthy to take an obvious and significant risk of causing injury to another … it is not clearly blameworthy to do something involving a risk of injury to another if … one genuinely does not perceive the risk. Such a person may fairly be accused of stupidity or lack of imagination, but neither of those failings should expose him to conviction of serious crime or the risk of punishment.[54]

This is a more elegant way of distinguishing between the reckless and the feckless and sets out clearly the moral difference between the two. Importantly, it also implies that only one should result in conviction.

Kimel argues that Lord Bingham's statement is 'clearly unsatisfactory' suggesting that those with 'a genuine disregard' or a 'glaring insensitivity' for the safety of others are culpable but exonerated by Lord Bingham's approach.[55] This is an unfair interpretation of his speech. The

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[50] *R v Caldwell* [1982] AC 341, [1981] 1 All ER 461 (HL) and *R v Lawrence* [1982] AC 510, [1981] 1 All ER 974 (HL)

[51] *Elliot v C (a minor)* [1983] 1 WLR 939 (QB)

[52] *R v G and another* [2003] UKHL 50, [2004] 1 AC 1034

[53] Dori Kimel 'Inadvertent recklessness in criminal law' [2004] Law Quarterly Review 548

[54] *R v G and another* [2003] UKHL 50, [2004] 1 AC 1034

[55] Dori Kimel 'Inadvertent recklessness in criminal law' [2004] Law Quarterly Review 548, 552

point made by Lord Bingham is that without guilty intent culpability cannot be assigned. A person who disregards the safety of others has presumably regarded the safety of others in the first place and gone on to discount it. This is clearly culpable and puts the defendant in the same position as described in *Parker*.[56]

The essence of the problem lies in the difference between *mere inadvertence* and *culpable inadvertence*; the distinction being the presence or absence of *mens rea.* Crosby tackles this question and argues that the solution lies in appreciation of the term 'indifference' by drawing on *Stone* and *Murphy.* [57] [58] [59]

Indifference is used in the sense of not caring rather than just being careless and culpability can be only assigned by looking at the thought processes of the defendant's acts or omissions creating the *actus reus*. For instance, if the *actus reus* is due to honest distraction and had the defendant not been distracted they would have acted differently, then they may not be culpable. This would amount to mere inadvertence. However, had the distraction made no difference to their course of action then this can be labelled as indifference and moral opprobrium applied. Crosby says that 'once the reason why no thought was given [is known]…it would be relatively straightforward to assess the degree of moral blameworthiness and thus any criminal liability.'[60] This might be true but finding the reason why no thought was given might be a very difficult task for the court. However, despite possible practical difficulties in looking into the mind of the defendant it is argued that this is a morally worthy approach. Whilst *Murphy* concerned reckless driving the passage by Eveleigh could easily be applied to medical manslaughter.[61] The doctor is being reckless either because he is defiant of the proper standard of care or culpably indifferent to the risks he is taking; the proper standard being stated by expert witnesses and the culpability of the defiance or indifference being judged by the jury, taking into account the mental attitude of the defendant doctor.

[56] *R v Parker* [1977] 2 All ER 37 (CA)

[57] Cath Crosby 'Recklessness: the Continuing Search for a Definition' [2008] 72 Journal of Criminal Law 313

[58] *R v Stone and Dobinson* [1977] 2 All ER 341 (CA)

[59] *R v Murphy* [1980] QB 434, [1980] 2 All ER 325 (CA)

[60] Cath Crosby 'Recklessness: the Continuing Search for a Definition' [2008] 72 Journal of Criminal Law 313, 324

[61] 'The mens rea of the offence lies in the mental attitude to achieving the required standard and that is usually revealed when we know whether or not the particular manner of driving which involves the risk was deliberately undertaken or not' *R v Murphy* [1980] 2 All ER 325 (CA) 330

An exercise in considering the culpability of inadvertence can be appreciated by applying the above to *Prentice*.[62]

Here two very junior doctors managed to inject a neurotoxic drug into a patient's nervous system by a combination of inexperience and ignorance. Both made erroneous assumptions that led to the death of the patient. Prentice assumed that he was being fully supervised by Sullman but Sullman thought he was only supervising the actual process of drug injection; neither paid any thought as to what they were injecting.[63] The judge found them both guilty of gross negligence manslaughter (due to recklessness) but tellingly commented that they were 'far from bad men'.[64] The Court of Appeal considered the case and came to the conclusion that the jury were misdirected. Instead of considering whether the doctors were guilty of recklessness (creating an obvious and serious risk of causing serious physical harm and nevertheless went on to take it or if they gave no thought to that risk), the test should have been that of gross negligence. Hence, the *Caldwell / Lawrence* recklessness was the wrong test to use. [65] Whether, given the chance, the jury would have found in favour of gross negligence will never be known but justice appears to have been done.

In terms of this essay, Prentice and Sullman were guilty of mere inadvertence and were not culpably indifferent; they were blissfully unaware that their actions may result in death and should not have been convicted. We will see later that it was easier to convict the feckless young doctors than analyse the multitude of errors and omissions leading up to their error and attempt to correct them.[66] Both are now employed as general practitioners.[67]

Applying this analysis to *Adomako* is enlightening. His inadvertence stemmed from agreeing to work whilst tired on a case he was inexperienced in. Had he not put his need for income above the safety needs of his patient he would not have agreed to work that morning. If he had declined to take over a case he admitted he lacked experience to undertake safely the

[62] *R v Prentice and another; R v Adomako; R v Holloway* [1993] 4 All ER 935 (CA)

[63] *R v Prentice and another; R v Adomako; R v Holloway* [1993] 4 All ER 935 (CA) 946

[64] M Brazier and N Allen 'Criminalising medical malpractice' in 'Charles Erin & Suzanne Ost (eds) *The criminal justice system and healthcare* (Oxford 2007) 18

[65] *R v Lawrence* [1982] AC 510, [1981] 1 All ER 974 (HL) and *R v Caldwell* [1982] AC 341, [1981] 1 All ER 461 (HL)

[66] Rebecca Coombs 'Death of a teenager from a drug error a decade ago has made UK a leader in safety' [2012] British Medical Journal 344 30th May

[67] Dr Barry Sullman is a GP in Newham, London and Dr Michael Prentice is a GP in Birtley, County Durham.

patient may not have died. Had he actually turned the key to enable the ventilator disconnect alarm to function he would have been aware of the disconnection far sooner. He had a choice. It is argued that his inadvertence was therefore culpable; this amounts to recklessness.

4.5.2 Involuntary manslaughter

In the Law Commission's 1996 publication on involuntary manslaughter, recklessness is reviewed.[68] Time is spent considering culpability and how advertent and inadvertent risk taking can merit criminal censure. The paper sets out why inadvertent risk taking can be culpable but avoids an analysis of indifference.[69] For the Law Commission the risk must be foreseeable to an average person in her position and she must be capable of perceiving that risk. [70] [71] In summary, the Law Commission conclude:

> [T]hat the criminal law ought to hold a person responsible for unintentionally causing death only in the following circumstances:
> (1) when she unreasonably and advertently takes a risk of causing death or serious injury; or
> (2) when she unreasonably and inadvertently takes a risk of causing death or serious injury, where her failure to advert to the risk is culpable because
> (a) the risk is obviously foreseeable, and
> (b) she has the capacity to advert to the risk.[72]

The recommendation was that this provided the basis of the new offence of 'reckless killing'; one of two forms of involuntary manslaughter; the other being 'gross carelessness'.[73]

Despite endorsement from the Home Office in 2000 this position has since been reviewed and 'reckless' has been dropped from the Law Commission's lexicon on homicide. [74] Their publication 'Murder, Manslaughter and Infanticide' explains:

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[68] Law Commission, *Legislating the Criminal Code: Involuntary Manslaughter* (Law Com No 237, 1996)

[69] Law Commission, *Legislating the Criminal Code: Involuntary Manslaughter* (Law Com No 237, 1996) paras 4.17 - 4.29

[70] Law Commission, *Legislating the Criminal Code: Involuntary Manslaughter* (Law Com No 237, 1996) para 4.18

[71] Law Commission, *Legislating the Criminal Code: Involuntary Manslaughter* (Law Com No 237, 1996) para 4.20

[72] Law Commission, *Legislating the Criminal Code: Involuntary Manslaughter* (Law Com No 237, 1996) para 4.43

[73] Law Commission, *Legislating the Criminal Code: Involuntary Manslaughter* (Law Com No 237, 1996) para 5.13

> We believe that there would be little point in continuing with a category of 'reckless manslaughter' when the worst cases of recklessness ….. are accounted for within second degree murder. Under our recommendations, 'reckless manslaughter' would become a very narrow category, in many cases all but indistinguishable from gross negligence manslaughter. The Crown Prosecution Service thought that the law would become too complicated if reckless manslaughter were retained as a separate category.[75]

Adding:

> The term 'reckless' has an unhappy history in the context of homicide. Although the House of Lords brought some welcome clarity to the definition of that term in another context, we now believe that the law of homicide is better off without it.[76]

This doesn't amount to a very strong legal argument for abandoning a term recently given 'welcome clarity' by the House of Lords.[77]

Oliver Quick states, in one of his many articles on the subject, '[t]he reasoning for this change of heart fails to convince.'[78] He goes on to suggest that recklessness is harder to prove because of its subjective nature. Gross negligence has the advantage of allowing persuasive expert witnesses telling juries of the grossness of the defendant's departure from the norm.[79] However, prosecutorial ease is not a sound basis for ignoring culpability as the key element in what should be prosecuted.

Glanville Williams insists that manslaughter 'should require a mental element, because it is a wide ranging crime with a fearsome maximum punishment'.[80] McCall Smith, in his treatise written at the same time as William's paper, says if 'a doctor is no more than negligent ... he should not be the subject of criminal sanction. If...recklessness is involved, then there is a morally blameworthy state of mind manifested and criminal liability will be appropriate'.[81] The

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[74] Home Office, *Reforming the law on involuntary manslaughter: the government's proposals* (May 2000) para 2.5

[75] Law Commission, *Murder, Manslaughter and Infanticide* (Law Com No 304, 2006) para 3.54

[76] Law Commission, *Murder, Manslaughter and Infanticide* (Law Com No 304, 2006) para 3.57

[77] *R v G and another* [2003] UKHL 50, [2004] 1 AC 1034

[78] Oliver Quick 'Medicine, Mistakes and Manslaughter: A Criminal Combination?' [2010] 69 The Cambridge Law Journal 186, 200

[79] Oliver Quick 'Medicine, Mistakes and Manslaughter: A Criminal Combination?' [2010] 69 The Cambridge Law Journal 186, 201

[80] Glanville Williams 'Misadventures of manslaughter' [1993] 143 New Law Journal 1413

[81] McCall Smith 'Criminal negligence and the incompetent doctor' [1993] 1 Medical Law Review 336, 336-337

punishment referred to has recently become even more fearsome since the Criminal Justice Act 2003 was given assent.[82]

Are there any culpable elements in negligence (gross or otherwise) to sustain the notion that gross negligence manslaughter, in the absence of recklessness, is a culpability based crime and not one of strict liability?

4.6 The *mens rea* of gross negligence

As stated above the other form of involuntary manslaughter considered in the Law Commission's 1996 paper was 'killing by gross carelessness'.[83] Here the Commission's conclusions were not far removed from the judgement in *Adomako*. 'Gross carelessness' replaced 'gross negligence' but from a medical perspective the ingredients are the same:

> (1) a person by his or her conduct causes the death of another;
> (2) a risk that his or her conduct will cause death or serious injury would be obvious to a reasonable person in his or her position;
> (3) he or she is capable of appreciating that risk at the material time; and
> (4) either
>
> > (a) his or her conduct falls far below what can reasonably be expected of him or her in the circumstances, or
> > (b) he or she intends by his or her conduct to cause some injury, or is aware of, and unreasonably takes, the risk that it may do so, and the conduct causing (or intended to cause) the injury constitutes an offence.[84]

The Law commission reviewed its recommendations in 2006 and reinstated 'gross negligence manslaughter' as its preferred term:

> There was also overwhelming support for a crime of manslaughter by gross negligence.[85]

and,

> We recommend the adoption of the definition of causing death by gross negligence given in our earlier report on manslaughter.[86]

The definition of 'gross negligence manslaughter' being identical to the definition of 'gross carelessness manslaughter'.

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[82] Hannah Quirk 'Sentencing white coat crime: the need for guidance in medical manslaughter cases' [2013] Criminal Law Review 871. Quirk draws on *R v Garg* [2012] EWCA Crim 2520 [2013] 2 Cr App R (S) 30 Crim as an example of how suspended sentences have turned into custodial sentences for criminal doctors since the Act has established itself in the Appeal Courts.

[83] Law Commission, *Murder, Manslaughter and Infanticide* (Law Com No 304, 2006)

[84] Law Commission, *Murder, Manslaughter and Infanticide* (Law Com No 304, 2006) para 5.34

[85] Law Commission, *Murder, Manslaughter and Infanticide* (Law Com No 304, 2006) para 3.40

[86] Law Commission, *Murder, Manslaughter and Infanticide* (Law Com No 304, 2006) para 3.60

For Adomako, applying the gross negligence test would have still resulted in a conviction in that:

> (1) he caused the death,
>
> (2) the risk was obvious to a reasonable anaesthetist and
>
> (3) he was capable of appreciating that risk and,
>
> (4) (a) his conduct fell far below what could reasonably have been expected.

We have argued earlier that it would be possible to apply (4) (b) to *Adomako* and make him grossly negligent due to recklessness:

> (b) he or she intends by his or her conduct to cause some injury, or is *aware of, and unreasonably takes, the risk that it may do so*, and the conduct causing (or intended to cause) the injury constitutes an offence. (*italicised for emphasis*)

Unlike recklessness, the *mens rea* element at the non-reckless end of the spectrum of 'gross negligence' is not immediately obvious and is possibly not present at all. This idea was given support by the Attorney General who stated:

> Although there may be cases where the defendant's state of mind is relevant to the jury's consideration when assessing the grossness and criminality of his conduct, evidence of his state of mind is not a prerequisite to a conviction for manslaughter by gross negligence.[87]

Judge LJ took exception to this in his findings in *Misra* saying '…when [evidence of a defendants state of mind] it is available, such evidence is not irrelevant. It will often be a critical factor in the decision.'[88] This falls short of making *mens rea* always a critical element in deciding whether a defendant is culpable. He then goes on to say, rather cryptically:

> Lord Reid [in *Sweet v Parsley*] explained that there were occasions when gross negligence provided the "necessary mental element" for a serious crime. Manslaughter by gross negligence is not an absolute offence. The requirement for gross negligence provides the necessary element of culpability.' [89]

Judge LJ appears to be saying that where there is evidence that a defendant's state of mind is culpable then this provides the necessary *mens rea* element to secure conviction. If there is no evidence of a criminal state of mind then the fact the negligence was gross provides the *mens rea* element required. This is an elaborate way of saying 'no smoke without fire' and fails to convince that without recklessness gross negligence can be a crime without *mens rea*; it can be a strict liability offence.

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[87] *Attorney General's Reference (No. 2 of 1999)* [2000] QB 796 [809]

[88] *R v Misra* [2004] EWCA Crim 2375, [2004] All ER (D) 107 (Oct) [56]

[89] *R v Misra* [2004] EWCA Crim 2375, [2004] All ER (D) 107 (Oct) [57]

Academic analysis of medical mistakes by numerous commentators gives succour to the argument that being blameworthy does not mean culpable or criminal and provides further evidence that gross negligence manslaughter is a poorly principled crime.

4.7 Errors and violations

The existence and acceptance of a duty of care is central to negligence. The existence of the duty must be just, fair and reasonable and the acceptance of it ought to be made consciously; anaesthetists are in no doubt that airway protection is one of their prime duties.[90] Dr Yogasakaran had a duty to act when his patient bit down on the tube; he was under a duty of care to ensure that the patient's airway was patent. He was expected to act to the standard demanded by his professional peers. He did not and was found negligent. A non-anaesthetist in the same operating theatre would not have been expected to perform to the same standard and could arguably have managed the situation in a more clumsy fashion (in the absence of an anaesthetist) without attracting serious civil, criminal or regulatory scrutiny.

However, negligence is a civil affair which offers compensation to a victim for a tort committed against them. Negligence causing death is not a criminal offence. Gross negligence causing death is a crime against the state. The all important prefix 'gross', by juxtaposing negligence and manslaughter, demands a search for culpability as with other homicide offences if the law is to be consistent.[91] As stated by Merry and McCall Smith 'morally relevant wrongdoing can only properly be identified if the actions of those whose responsibility is in question are subjected to analysis designed to identify states of mind that are truly culpable.'[92] Their publication gives a detailed analysis of unintentional medical deaths by synthesising the perspectives of an eminent legal mind and a doctor practising the most manslaughter prone specialty of them all, anaesthesia.[93]

To them, two broad groups of mistakes prevail; the 'error' and the 'violation'. An error is given to mean the sort of mistake that could be made by anyone just by simply being a human rather than a machine. An example would be injecting the drug labelled 'fentanyl'

[90] *Caparo Industries v Dickman* [1990] UKHL 2

[91] First and second degree murder and manslaughter through the commission of a 'criminal act'. Law Commission, *Murder, Manslaughter and Infanticide* (Law Com No 304, 2006) paras 9.5 - 9.6, 9.9

[92] Merry and McCall Smith, *Errors, medicine and the law* (Cambridge 2001) 9

[93] Prof McCall (law) and Prof Merry (anaesthesia)

instead of the same sized syringe next to it labelled 'midazolam'.[94] This is the anaesthetic equivalent to pouring hot water into a mug having forgotten to put the coffee granules in first. Scientific evidence suggests that *many* doctors will make this sort of error at some point in their careers and anecdotal evidence suggests that *most* anaesthetists will make this sort of error during their careers.[95] [96] Errors are further subdivided but all are viewed as lacking any culpable elements with the exception of the 'egregious error' which equates to the 'grossest ignorance' described in *Wilkinson*.[97] [98] This might relate to a culpable attitude but a failure of regulation may also play a part here. This will be reviewed in the chapter on 'the role of regulatory bodies and corporate responsibility'.

'Violations' are said to be 'deliberate deviations from those practices deemed necessary to maintain the safe operation of a potentially hazardous system.' [99] A violation may indeed be reprehensible depending on the reason for it; a lazy short-cut or a well-reasoned aberration. Fatigue is cited as increasing the chances of both error and violation and can be seen in many of the prosecuted manslaughter cases. [100] [101] Where a defendant has the choice not to work when fatigued should this attract the same level of disapproval as when faced with no choice at all? If alcohol intoxication is rejected as an excuse for reckless behaviour can the same be said of fatigue if it induces similar mistakes? [102]

Ashworth argues that criminal liability for negligence is dependent on the following:

1. the potential for harm is great

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[94] Both drugs cause similar effects and are used at induction of anaesthesia (see **glossary**)

[95] A Merry D Peck 'Anaesthetists, errors in drug administration and the law' [1995] 108 New Zealand Medical Journal 185

[96] Author's own experience of himself and colleagues over the last 20 years of anaesthetic practice

[97] Merry and McCall Smith, *Errors, medicine and the law* (Cambridge 2001) 95

[98] *R v Williamson* [1807] 3 C and P 635

[99] Merry and McCall Smith, *Errors, medicine and the law* (Cambridge 2001) 98

[100] Drew Dawson & Kathryn Reid 'Fatigue, alcohol and performance impairment' [1997] 388 Nature 235

[101] Mr Garg had been on duty for 8 days *R v Garg* [2012] EWCA Crim 2520, [2013] 2 Cr App Rep (S) 203 ,Dr Adomako had a maximum of 4 hours sleep *R v Prentice and another; R v Adomako; R v Holloway* [1993] 4 All ER 935 (CA), Dr Urbani was said to have been exhausted 'Exhausted relief doctor gave patient fatal dose' *The Guardian*, 4th May 2009 and in Canada Dr Verbrugge was accused of actually being asleep 'Anesthesiologist Found Negligent in Boy's Death' *New York Times* October 24th 1996 <http://www.nytimes.com/1996/10/24/us/anesthesiologist-found-negligent-in-boy-s-death.html> accessed 20th July 2014

[102] *R v Majewski* [1977] AC 443, [1975] 3 All ER 296 (CA). Self intoxication was not deemed an adequate defence

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2. the risk of it occurring is obvious
3. the defendant has a duty to avoid the risk
4. the defendant has the capacity to take the required precautions [103]

From an anaesthetic perspective, the above could be applied to every patient who is given a muscle relaxant. There is the potential for death which is obvious; there is a duty to manage the patient's breathing or they will turn blue and die; the anaesthetist has the capacity to choose how to manage the patient's breathing (all of which carry some risk of failure). If any anaesthetically paralysed patient dies because they have not been managed well the anaesthetist stands little chance of avoiding conviction. Anaesthetists are already over represented in the grand pantheon of criminal doctors; this would make the job even more perilous.[104]

Ashworth's four points are not entirely unreasonable but where is the 'proof of sufficient fault' Ashworth requires? Need the risk be obvious to the expert witnesses who play a central role in gross negligence manslaughter cases or must it be obvious to the defendant at the time he made the fatal error? In the cold light of day the defendant may easily have capacity to recognise he failed to take a particular precaution but what about his capacity at the material time? In *Adomako* '[i]t had never occurred to him that a disconnection had taken place. He stated in evidence that "after things went wrong I think I did panic a bit."'[105] To Dr Adomako the risk of disconnection was not obvious and he did not, at the material time, have the capacity, due to panic, to take the precaution of checking if the tubing had become disconnected. Furthermore, he had not connected the tube in the first place (another anaesthetist had) and he did not disconnect the tubing (either the surgeon or scrub sister did that inadvertently). He failed to discharge his duty to remedy the disconnection and this was not contested by his counsel. He was clearly at fault, obviously negligent, palpably incompetent but is sheer incompetence alone enough to merit a criminal conviction? It has been argued earlier that Adomako was reckless and this more comfortably renders him culpable and criminal. A closer look at cases post-Adomako reveals that successful convictions for medical gross negligence manslaughter are, in fact, cases of recklessness.

[103] Ashworth & Horder, *Principles of Criminal Law* (7th edition, Oxford 2013) 168

[104] Barry Lyons 'The sleep of death: anaesthesia, mortality and the courts from ether to *Adomako*' in Danielle Griffiths & Andrew Sanders (eds) *Bioethics, Medicine and the Criminal Law: Medicine, Crime and Society* (Cambridge University Press 2012) 43

[105] *R v Adomako* [1995] 1 AC 171 (HL) 183

Dr Kovvali was a locum GP in his 60's who was called to see a depressed 42 year old man in Sheffield one evening. The patient had a decreased conscious level and was too confused to speak on the phone. The patient's mother (with whom he lived) told Dr Kovvali of the family history of diabetes and gave a reasonable history suggestive of diabetic ketoacidosis.[106] Dr Kovvali, despite being on-duty solely for urgent home visits, checked the patient's pulse and temperature but otherwise did not examine him or perform any simple bedside tests such as a blood sugar measurement. He did not admit the patient to hospital or arrange for another visit; a diagnosis of depression was recorded and he told the patient to see his own GP the next day. The court found that Dr Kovvali was guilty of gross negligence manslaughter.[107] This is almost certainly a case of culpable inadvertent recklessness; indifference to the obvious risk of deterioration manifested by a refusal to fully examine the patient or admit him to hospital for further observation. The mistake was not simply an error, it was a violation.

A similar situation can be seen with *R v Garg*.[108] The defendant urologist, over the course of a weekend, initially did not realise his patient was septic and thus did not treat her correctly. He then realised she was ill but was too fatigued himself to make suitable arrangements for correct treatment. When she finally died he altered the medical notes to make it appear she had not been as unwell as she was. Here is an example of inadvertence (mere or culpable) followed by advertent recklessness concluding in falsification of medical records. It is contended that if Garg stood any chance of acquittal he ruined this by trying to conceal his guilt.

Other such cases include Dr Gadgil, who administered a general anaesthetic outside of a hospital without ever examining the child or checking his anaesthetic equipment; [109] Walker who undertook an operation he was woefully under skilled to perform,[110] and Sellu who continued his private clinic instead of attending to his acutely unwell patient on the ward. [111]

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[106] See **Glossary**

[107] *R v Kovvali* [2013] EWCA 1056

[108] *R v Garg* [2012] EWCA Crim 2520, [2013] 2 Cr App Rep (S) 203

[109] 'Anaesthetist jailed for killing boy' *BBC News* July 29th 1999 <http://news.bbc.co.uk/1/hi/health/407210.stm accessed 19th July 2014

[110] 'Killer surgeon Steven Walker makes bid to return as doctor' *BBC News* November 7th 2013 <http://www.bbc.co.uk/news/uk-england-lancashire-24848235> accessed 19th July 2014 and 'Horrific toll of bungling surgeon' *Daily Mail* <http://www.dailymail.co.uk/news/article-81975/Horrific-toll-bungling-surgeon.html> accessed 19th July 2014

[111] Peter McDonald 'Doctors and manslaughter' [2014] 96 Annals of the Royal College of Surgeons 112

This brings us to Dr Falconer, another anaesthetist, who injected a large volume of air into the vein of a baby undergoing a relatively routine operation. The baby died almost instantly.[112] On the face of it, none of the cases we have looked at until now have had doctors who have breached their duty to this degree. The only possible outcome for this baby was instant death; there a no occasions when injecting more than a tiny amount of air into a vein can ever be seen as reasonable.[113] If there had been intent then this would have been a very simple case of first degree murder. As it turned out he was acquitted of gross negligence manslaughter and was back at work within a few months. Dr Falconer made an error. It was not a violation and, although the consequences were devastating, there was no *mens rea*; his mind was not culpable and he readily accepted full responsibility. The case has gone unreported but the court clearly subscribed to the idea that the punishment should fit the crime, not the consequence.[114]

One must look beyond the individual defendant doctor himself to see that individual convictions may form part of a bigger picture.

4.8 Deterrence

Punishment is not the only purpose of prosecution and conviction; rehabilitation, reparation, public protection and deterrence also play a part.[115] As far as reparation is concerned the civil courts are better placed to provide compensation, not least because the standard of proof required is lower.[116] The public will certainly be protected from a doctor if he is either imprisoned or struck off the medical register although his chances of rehabilitation as a doctor once convicted are slim.[117] What then of deterrence? In order to deter, the potential offender needs to know what it is they should be avoiding.

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[112] 'Doctor cleared of baby killing' *BBC News* 18th May 2004 <http://news.bbc.co.uk/1/hi/wales/3724681.stm> accessed 19th July 2014

[113] See **Glossary**

[114] See the exchange between Paul Firth 'Crime or consequences?' [2006] 156 New Law Journal 1876 and Kris Gledhill 'Criminal carelessness' [2007] 157 New Law Journal 41 for a lively debate on punishing *mens rea* or *actus reus*.

[115] Ashworth & Horder, *Principles of Criminal Law* (7th edition, Oxford 2013) 19 and Criminal Justice Act 2003 s.142

[116] On the balance of probabilities as opposed to beyond reasonable doubt.

[117] Walker attempted to get re-registered as a doctor some years after conviction but was unsuccessful. 'Doctors in the dock' Medical Protection Society May 2014 <http://www.medicalprotection.org/uk/casebook-may-2014/medicine-and-manslaughter>accessed July 19th 2014

Lord Bingham said:

> There are two guiding principles: no one should be punished under a law unless it is sufficiently clear and certain to enable him to know what conduct is forbidden before he does it; and no one should be punished for any act which was not clearly and ascertainably punishable when the act was done.[118]

This is also enshrined in Article 7 of the European Convention on Human Rights and Fundamental Freedoms.[119] A defendant is entitled to ask what distinguishes negligence, which is not criminal, from gross negligence, which is. In *Misra*, the defendant doctors appealed their conviction on the grounds of uncertainty.[120] Judge LJ dismissed the appeal stating:

> The question for the jury is not whether the defendant's negligence was gross, and whether, additionally, it was a crime, but whether his behaviour was grossly negligent and consequently criminal. This is not a question of law, but one of fact, for decision in the individual case.[121]

Whilst this has been criticised[122] and described as a 'distinction without a difference'[123] in that the jury are left to decide if a criminal act has taken place, the position for doctors is quite clear: if, through proven negligence, your patient has died then you stand the chance of criminal conviction. The 'thin skull' rule is an appropriate analogy; a doctor is liable for the consequences of negligence be they trivial or fatal.[124] It is 'moral luck' that determines this outcome.[125] This is not to say that a criminal conviction *should* follow, but the law is sufficiently clear to rebut any notion that Article 7 has been infringed.

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[118] *R v Rimmington, R v Goldstein* [2005] UKHL 63, [2006] 1 AC 459 [33]

[119] 'No one shall be held guilty of any criminal offence on account of any act or omission which did not constitute a criminal offence under national or international law at the time when it was committed. Nor shall a heavier penalty be imposed than the one that was applicable at the time the criminal offence was committed.'

[120] *R v Misra* [2004] EWCA Crim 2375, [2004] All ER (D) 107 (Oct)

[121] *R v Misra* [2004] EWCA Crim 2375, [2004] All ER (D) 107 (Oct) [62]

[122] Oliver Quick 'Medicine, Mistakes and Manslaughter: A Criminal Combination?' [2010] 69 The Cambridge Law Journal 186 [192]

[123] Ashworth & Horder, *Principles of Criminal Law* (7th edition, Oxford 2013) 293

[124] The 'thin skull rule' holds a defendant liable for all consequences resulting from tortious or criminal activities leading to an injury to another person, even if the victim suffers an unusually high level of damage due to a pre-existing vulnerability. This was invoked by Lawton LJ in *R v Blaue* [1975] 61 Cr App R 271 (CA)

[125] Kimberley Kessler 'The role of luck in the criminal law' [1993-1994] 142 University of Pennsylvania Law Review 2183

Having decided that negligence causing death may be construed as gross negligence and therefore criminal, we need to discover what lessons have been learned by the medical profession as a result of their brethren being prosecuted.

The answer is disappointing.

Firstly, the response to the conviction of doctors in the medical press tends to lament the unluckiness of the doctor rather than emphasise what should have been done better.[126] The conviction of the surgeon, David Sellu, is a case in point.[127] [128] Peter McDonald (Consultant Surgeon and Non-Executive Director of the Medical and Dental Defence Union of Scotland) stated that 'David Sellu was a senior surgeon with a reputation among his colleagues for industriousness and probity. The jury found that his failure to prescribe antibiotics, his tardiness in obtaining a computed tomography and then his delay in proceeding to urgent laparotomy in a patient with peritonitis amounted to gross negligence.'[129] He then goes on to say '[i]t is probably wrong to think that David Sellu's case will change the way we surgeons work.'[130]

It is not clear how much this approach helps to improve attitudes to patient safety.

Secondly, the behaviour of the medical profession following tragedies seems to be stubbornly difficult to change. For instance, in 1947 two patients were injected intrathecally with a local anaesthetic contaminated with carbolic acid. Both were permanently paralysed but the tortfeasor doctor was found not guilty of negligence because the consequences of whatever error occurred were not foreseeable. Lord Denning went on to say:

> Never again, it is to be hoped, will such a thing happen. After this accident a leading textbook was published in 1951 which contains the significant warning: "Never place ampoules of local anaesthetic solution in alcohol or spirit. This common practice is probably responsible for some of the cases of permanent paralysis reported after

[126] Peter McDonald 'Doctors and manslaughter' [2014] 96 Annals of the Royal College of Surgeons 112

[127] There is a website dedicated to the support of David Sellu with contributions from numerous surgeons <http://davidsellu.org.uk> accessed 5th November 2014.

[128] The sentencing remarks of the judge are available online< http://www.judiciary.gov.uk/judgments/r-v-sellu-sentencing-remarks/> accessed 5th November 2014

[129] Peter McDonald 'Doctors and manslaughter' [2014] 96 Annals of the Royal College of Surgeons 112, 112

[130] Peter McDonald 'Doctors and manslaughter' [2014] 96 Annals of the Royal College of Surgeons 112, 112

> spinal analgesia." If the hospitals were to continue the practice after this warning, they could not complain if they were found guilty of negligence.[131]

We have already reviewed the 1994 case of *Prentice* in which a neurotoxic chemotherapy agent was accidentally injected intrathecally causing death.[132] So it should come as a surprise that since the warnings evidenced by *Roe* and *Prentice* numerous patients have been harmed by the wrong drug being injected either intrathecally or epidurally.[133] [134] Drug errors, generally, are said to occur in 1 in 133 anaesthetics and as many as 93.5% of anaesthetists admit making such errors.[135] [136]

Mistakes are evidently still commonplace regarding drug routes but what about the highly specific scenario in *Prentice;* avoiding giving chemotherapy agents intrathecally unless specifically indicated? Merry reports an almost identical case to *Prentice* occurring in 1997 and this had occurred at least ten times since 1993.[137] [138] Moreover, the expert prosecution witness who opined that it was a system error which caused the death of Richie William in Merry's 1997 case, was professor of anaesthetics at the Queens Medical Centre when Feda Mulhem was convicted of the death of Wayne Jowett under remarkably similar circumstances in 2001.[139] What hope is there if such an expert cannot reliably influence his own hospital? Alternatively, are these cases all errors rather than violations?; whatever the influence of an eminent professor, errors will always occur and no amount of legal action will prevent this. The key would seem to be to provide an environment whereby avoidable errors and violations are readily distinguished. With adequate education, training and supervision,

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[131] *Roe v Ministry of Health* [1954] 2 QB 66 (CA) 87

[132] *R v Prentice and another; R v Adomako; R v Holloway* [1993] 4 All ER 935 (CA)

[133] Intrathecal errors have included muscle relaxants Nahid Zirak 'Inadvertent intrathecal injection of atracurium' [2011] 5 Saudi Journal of Anaesthesia 223 and tranexamic acid Bina Butala 'medication error:subarachnoid injection of tranexamic acid' [2012] 56 Indian Journal of Anaesthesia 168

[134] 37 epidural cases are reported by C M Hew 'Avoiding inadvertent epidural injection of drugs intended for non-epidural use' [2003] 31 Anaesthesia and Intensive Care 44. This is said to be a 'gross underestimation'.

[135] R Raw 'Never trust a drug that can be pronounced in three different ways: medication errors in anaesthesia' [2014] 20 South African journal of Anaesthesia and Analgesia 32

[136] P C Gordon 'Wrong drug administration errors amongst anaesthetists in a South African teaching hospital' [2004] (May) South African Journal of Anaesthesia and Analgesia 7

[137] A Merry A McCall Smith *Errors, medicine and the law* (Cambridge 2001) 19

[138] C Dyer 'Doctors cleared of manslaughter' [1999] 318 British Medical Journal 148

[139] 'Anger as fatal jab doctor freed' BBC 23rd Sept 2003 <http://news.bbc.co.uk/1/hi/health/3133076.stm> accessed 17th July 2014

any intrathecal chemotherapy mistakes would either be bizarre human errors (as with Falconer) or reckless violations and therefore criminal.

The 'experiment' in New Zealand is apposite. Between 1961 and 1997 manslaughter due to negligence was a criminal offence.[140] Essentially, negligence manslaughter was a strict liability offence with no element of culpability required to secure conviction; negligence alone was sufficient.[141] In 1981 a child was killed by an anaesthetist in New Zealand who twisted the wrong knob on the anaesthetic machine and delivered carbon-dioxide instead of oxygen. He was convicted of manslaughter.[142] Nowadays modern anaesthetic machines do not support carbon-dioxide at all and there a host of safety features which make it nearly impossible to deliver hypoxic gas mixtures. Interestingly, these features were introduced as mandatory standards following high profile criminal and negligence cases such as this. Whether this was due to knowledge of the mistake or knowledge of the offence is hard to say.

Yogasakaran made his fatal blunder in 1987 and this was followed by a number of cases with varying degrees of culpability. Naturally, there was widespread unease amongst the medical profession and after much lobbying the Act was amended in 1997 to include the phrase 'the omission or neglect is a major departure from the standard of care' rather than simply 'omitting without lawful excuse'.[143] The New Zealand 'major departure' is broadly in line with the English requirement for the negligence to be 'gross'.

Persuasive as Merry's arguments are, regarding the unfair prosecution of doctors for 'mere' negligence (resulting in death), he ignores the association between prosecutions and improvements in safety. It could be that the association between anaesthetic safety and prosecution has been in no way causal but it is tempting to postulate that some convicts have 'taken one for the team'; thanks to their personal ignominy they have improved standards for patients. The medical profession might argue that the safety improvements that have been made would have been made anyway and the prosecution of doctors has been unnecessary. Indeed, the prosecution of doctors is held to be positively detrimental to

[140] Crimes Act (New Zealand) 1961 specifically sections 151 - 157

[141] Crimes Act (New Zealand) 1961 s.155

[142] Alan Merry 'When are Errors a crime?-Lessons from New Zealand' in Charles Erin & Suzanne Ost (eds) '*The criminal justice system and healthcare'* (Oxford 2007) 71

[143] Crimes Amendment Act (New Zealand) 1997 s.150A

patient safety initiatives; who wants to volunteer that they have made a mistake if punishment follows?

Fear of punishment is a powerful driver for defensive medicine which we shall briefly review.

4.8.1 Defensive medicine

Deterrence can lead to defensive behaviour which increases costs but does little to improve safety.[144] [145] For instance, an elderly patient admitted to hospital with a fractured neck of femur will probably require operative fixation of the fracture.[146] In all likelihood she will have co-morbidities which will make the anaesthetic more hazardous than the same anaesthetic given to a fit and healthy patient.[147] Under the current rules of reporting deaths if she is operated on and dies soon afterwards the coroner will need to be informed and may hold an inquest.[148] It is possible that this inquest will find deficiencies in the anaesthetist's approach to the patient which could conceivably result in a civil or possibly criminal action.[149] If the anaesthetist procrastinates and insists on costly, time consuming investigations and second opinions then the patient will be operated on at a later date. Delays are known to be associated with a worse outcome but having turned every stone in order to protect himself from legal inquiry, the procrastinating anaesthetist has provided himself with much more defensive material than his expedient colleague.[150] Despite Brazier's assertion that 'a civil claim does not mean professional ruin or personal disgrace' doctors, nevertheless, do not like going to court; Coroner's, High Court or Crown.[151]

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[144] Ortashi et al 'The practice of defensive medicine among hospital doctors in the United Kingdom. [2013] 14 BMC Medical Ethics 42

[145] D Studdert et al 'Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment' [2005] 293 (21) Journal of the American Medical Association 2609

[146] NICE clinical guideline 124 'The management of hip fracture in adults' June 2011. Modified in March 2014

[147] Association of Anaesthetists of Great Britain and Ireland 'Management of proximal femoral fractures 2011' [2012] 67 Anaesthesia 85

[148] Ministry of Justice 'A guide to Coroners and inquests' January 2010 para 5.1

[149] Coroners and Justice Act 2009 s.10(2) states '[a] determination under subsection (1)(a) may not be framed in such a way as to appear to determine any question of—(a) criminal liability on the part of a named person, or (b) civil liability. Nevertheless criminal or civil liability may easily be inferred by those attending the inquest.

[150] Association of Anaesthetists of Great Britain and Ireland 'Management of proximal femoral fractures 2011' [2012] 67 Anaesthesia 85

[151] Margaret Brazier, Amel Alghrani 'Fatal medical malpractice and criminal liability' [2009] 2 Journal of Professional Negligence 51, 55

The picture painted is blacker than it should be. There have been improvements in safety awareness but it is hard discount legal action as a driver for these improvements whatever the indignity expressed by the medical profession at this suggestion.

4.9 Gross negligence causing harm short of death

If defensive medicine (whilst sounding safe) is actually of detriment to the public the argument that criminal proceedings should take place if a doctor has negligently harmed a patient seems to make no sense whatsoever. This would be the case if such an offence was based around gross negligence complete with the uncertainty of 'gross' and its element of moral luck. However, if recklessness was to form the criminal bar instead of gross negligence there would be room to encompass harm as well as death. We have already seen that recklessness itself has had a difficult time in the courts but perhaps not as bad as gross negligence. It is certainly easier to attach *mens rea* to recklessness if the approach in *R v G* is adopted.[152] Other countries maintain such an offence, as described later, and legal commentators flirt with the idea.[153]

Quick argues 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 recklessness.'[154] We should not require death to assert this reasoning, negligent harm would suffice. This is more satisfactory than the 'deliberate wickedness' required by Jonathan Montgomery.[155] He implies that intent is level at which the bar should be set; this would give doctors virtual immunity from prosecution. It is contended that doctors would welcome recklessness as representing the criminal bar, not because it is higher than gross negligence but because they have more control over their fate. A feckless but well-meaning doctor will avoid prison

[152] *R v G and another* [2003] UKHL 50, [2004] 1 AC 1034. 'Knowing disregard of an appreciated and unacceptable risk of causing an injurious result or a deliberate closing of the mind to such risk would be readily accepted as culpable .... It is clearly blameworthy to take an obvious and significant risk of causing injury to another. But it is not clearly blameworthy to do something involving a risk of injury to another if…one genuinely does not perceive the risk.' 1056 (Lord Bingham)

[153] Margaret Brazier & Neil Allen 'Criminalizing medical malpractice' in Charles Erin & Suzanne Ost (eds) *The criminal justice system and healthcare* (Oxford 2007) 27

[154] Oliver Quick 'Medicine, mistakes and manslaughter: A Criminal Combination?' [2010] 69 The Cambridge Law Journal 186, 203

[155] Jonathan Montgomery 'Medicalizing crime – criminalizing health?' in Charles Erin & Suzanne Ost (eds) *The criminal justice system and healthcare* (Oxford 2007) 263

(but be erased from the medical register) whilst the reckless doctor will go to prison (and be erased from the medical register).

Of course, this is just fantasy whilst *Adomako* reigns supreme. Until reckless manslaughter replaces gross negligence manslaughter (which is unlikely after two Law Commission reports approving its existence)[156] the prospect of a criminal offence of recklessly harming patients is remote. The only criminal offence that might come close is that of willful neglect which we will very briefly review later.

We have examined the ethics of medical gross negligence manslaughter and concluded that the ethical basis is flawed due to the difficulty in establishing a convincing *mens rea* for the offence (in cases not involving recklessness). We can now turn our attention to the mechanics of the crime's prosecution.

[156] Law Commission, *Legislating the Criminal Code: Involuntary Manslaughter* (Law Com No 237, 1996) and Law Commission, *Murder, Manslaughter and Infanticide* (Law Com No 304, 2006)

5. EXPERT EVIDENCE

Experts are invariably used to give their opinions in medical gross negligence manslaughter cases. Even if we were to argue that the offence had a credible ethical basis the prosecution of the crime must be sufficiently sound to merit approval. Hence, the admissibility of expert evidence and the directions given to the jury in terms of the weight they should attach to this evidence must be examined.

5.1 Experts exceeding their remit

Bolam, with the modification suggested in *Bolitho*, remain the legal standards by which negligent medical acts and omissions are judged.[157] [158] These cases bear a brief review.

In *Bolam*, McNair J said that a doctor is 'not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art.'[159] In addition, 'the court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis.'[160] Further to this we have the question as to who may be regarded as an expert; a spokesperson for the responsible doctors skilled in the art in question. For this we look to Australia and *Bonython*:

> [T]he expert is allowed to express opinions if [he] is shown to possess sufficient knowledge or experience in relation to the subject upon which the opinion is sought to render his opinion of assistance to the court... [T]he judge must be satisfied that the witness possesses the necessary qualifications, whether those qualifications be acquired by study or experience or both.[161]

Combining the three cases we can see that a doctor called as an expert witness must be skilled in the particular specialty (either through study or experience), represent a responsible body of opinion and express logical conclusions if he is to be credible and of use to the court. The recently amended Criminal Procedure Rules further set out the conditions

[157] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 (QB)

[158] *Bolitho v City and Hackney Health Authority* [1998] AC 232, [1997] 4 All ER 771 (CA)

[159] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 (QB) 588

[160] *Bolitho v City and Hackney Health Authority* [1998] AC 232 (CA) 242

[161] *R v Bonython* [1984] 38 SASR 45 King CJ and incorporated into English law through (amongst others) *R v Luttrell* [2004] EWCA Crim 1344, [2004] 2 Cr App R 520

of engagement incumbent on the witness.[162] Experts are only to be engaged if they have something of value to the court. This was succinctly described in *Turner*:

> An expert's opinion is admissible to furnish the court with … information which is likely to be outside the experience and knowledge of a judge or jury. If on the proven facts a judge or jury can form their own conclusions without help, then the opinion of an expert is unnecessary.[163]

Furthermore, it is for the jury to decide on the weight it places on expert evidence once it is deemed admissible. As stated in *Bonython*:

> [W]hen it is established that the witness is an expert in the relevant field of knowledge, he will be permitted to express his opinion, however unconvincing it might appear to be, subject always, of course, in a criminal trial to the discretion to exclude evidence whose prejudicial effect is disproportionate to its probative value. The weight to be attached to his opinion is a question for the jury.[164]

The term 'expert' needs clarification. An expert is not meant to be a doctor who has reached the very zenith of medical expertise and casts opinion based on his own very high standards. This would serve no purpose at all, although many expert witnesses are distinguished in their fields of expertise. An expert, for the purposes of the court, is merely meant to be someone skilled in 'that particular art'.

It would seem a straightforward matter to ensure that the above conditions are met. With 238,424 licensed doctors in the UK it should be relatively easy to find an 'expert'.[165] Unfortunately, the pool of doctors acting as medical expert witnesses is very shallow indeed. Only doctors who have an interest in legal medicine are engaged as experts. Many are academics or recently retired clinicians. Often they hail from specialties dealing exclusively in images of patients (radiologists) or histological specimens of the recently deceased (pathologists). Doubtless these doctors are intelligent, articulate and have a thorough understanding of their branch of medicine but are their opinions always relevant?

For instance is it reasonable to attach much weight to a pathologist's interpretation of a 'symptom' when, by its very definition, this means the patient's own description of perceived bodily malfunction during life? The pathologist may not have listened to a patient's symptoms in over 40 years and will be relying exclusively on textbooks or a distant memory to give his opinion. Can a professor of diabetology be relied upon to comment, with fidelity,

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[162] The recent changes to the Criminal Procedure Rules are described on page 39

[163] *R v Turner* [1975] QB 834 (CA) 841 (Lawton LJ)

[164] *R v Bonython* [1984] 38 SASR 45 King CJ

[165] Data correct as of 8th October 2014. GMC website
< http://www.gmc-uk.org/doctors/register/search_stats.asp> accessed 6th November 2014

on the practice of a general practitioner (GP) working in an environment the professor has had no experience of? Can a GP be reasonably expected to manage diabetes as well as a professor of diabetology? It is suggested that a GP with experience of making house calls might be a more credible expert in these situations.[166]

It is a lot to expect of a judge, let alone a juror, to be able to know the narrow limits of a professor's expertise and lend appropriate weight to different parts of his evidence. The notorious case of *Meadows* illustrates how a celebrated and deeply respected professor can fall from grace by expressing opinion outside of his expertise.[167] His inadequacy as a statistician was not appreciated by judge or jury; presumably fooled by his demeanour and dazzling credentials as a genuine expert in unrelated fields.[168] Even within a speciality there is room for confusion as to whether an expert witness is really skilled in the particular art in question; the very standard against which the defendant doctor is judged can be opaque to judge and jury. As Merry describes, a cardiac anaesthetist will have far more experience of inserting central venous catheters than a general anaesthetist.[169] Is it reasonable that the standard of care expected of the generalist is as high as that of the specialist? Reference might be made to *Nettleship* but in cases of gross negligence the difference between the standards expected of a generalist and a specialist should be tiny compared with that of the generalist and the level of care on trial; in other words, to be truly gross, the degree of negligence should be obvious and not require the presence of a specialist expert at all.[170]

[166] *R v Kovvali (Bala_Subrahmanyam)* [2013] EWCA Crim 1056. The prosecution experts in this case were Professor Tattersall, a retired professor of clinical diabetes and Dr Bedanski, a consultant physician specialising in diabetes. Neither were GP's and are unlikely to have ever made house calls at night at any time in their careers.

[167] *GMC v Meadows* [2006] EWCA Civ 1390. The GMC lost its appeal against Meadows in that they erred when striking him from the medical register for gross professional misconduct. However, it remains that '[i]n this appeal there can be no doubt that Professor Sir Roy Meadow fell short of the required standards.' Para 251 Thorpe LJ

[168] 'Professor Meadow is not a statistician and had no relevant expertise which entitled him to use the statistics in the way he did...He gave the evidence as part of his expert evidence and, moreover, did so in a colourful way which might well have been attractive to a jury without expressly disclaiming any expertise in the field on an issue the only possible relevance of which can have been (as stated above) to support the prosecution's case that the children had both died from unnatural causes. He knew that he had no such experience and should have expressly disclaimed any.' *GMC v Meadows* [2006] EWCA Civ 1390 [83] (Clarke MR)

[169] Alan Merry & Alexander McCall Smith *Errors, medicine and the law* (Cambridge 2001) 182-184

[170] *Nettleship v Weston* [1971] 2 QB 691 (CA). There is a standard beneath which no doctor should fall without attracting civil or criminal attention, irrespective of seniority.

The Law Commission ventured to solve the problem of experts giving opinion outside of their expertise with its Criminal Evidence (Experts) Bill.[171] The Bill was rejected by the government but concessions were made in the form of new Criminal Procedure Rules.[172] [173]

5.2 Criminal Procedure Rules 2014

Coming into effect on October 6th 2014, part 33 of the Criminal Procedure Rules (CPR) conceded some ground to the Law Commission with a number of changes. Firstly, an expert must now define in his verbal report and in writing his area of expertise.[174] Additionally, when giving evidence in person, he must 'draw the court's attention to any question to which the answer would be outside the expert's area...of expertise.'[175] In section 33.3 there is now a duty to give 'notice of anything...which might reasonably be thought capable of detracting substantially from the credibility of that expert.'[176] These concessions seem to go to the weight of the evidence rather than its admissibility; the Law Commission was keen to have excluded from the outset any expert testimony not conforming to its tightened rules. The only clear change to the CPR regarding admissibility is 33.4(h).[177] This falls quite short of the statutory reliability tests suggested in Clause 4 of the proposed Bill.[178] It remains to be seen whether the new rules will stop retired professors from giving pivotal evidence in areas in which they have had little or no experience. It is suggested that it will not.

5.3 'Skilled in that particular art' or just a convincing witness?

If we accept that jurors are ordinary members of the public then we can sensibly analyse the appointment of Victoria Beckham as UNAIDS Goodwill Ambassador and Leonardo Di

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[171] Criminal Evidence (Experts) Bill as presented by the Law Commission (Law Com No 325). Accessible online at <http://lawcommission.justice.gov.uk/docs/lc325_Expert_Evidence_Report.pdf> accessed 25th October 2014

[172] Ministry of Justice 'The Government's response to the Law Commission report: *"Expert evidence in criminal proceedings in England and Wales"* (Law Com No 325)'. Available online < https://www.gov.uk/government/publications/government-response-to-law-commission-report-on-expert-evidence> accessed 5th November 2014

[173] Criminal Procedure Rules 2014. SI 2014 1610

[174] 33.2 (3) a) Criminal Procedure Rules 2014. SI 2014 1610

[175] 33.2 (3) b) Criminal Procedure Rules 2014. SI 2014 1610

[176] 33.3 (3) c) Criminal Procedure Rules 2014. SI 2014 1610

[177] 'An expert's report must…include such information as the court may need to decide whether the expert's opinion is sufficiently reliable to be admissible as evidence' 33.4 (h) Criminal Procedure Rules 2014. SI 2014 1610

[178] Criminal Evidence (Experts) Bill as presented by the Law Commission (Law Com No 325). Accessible online at <http://lawcommission.justice.gov.uk/docs/lc325_Expert_Evidence_Report.pdf> accessed 29th October 2014

Caprio's instatement as a United Nations representative on climate change. Few would argue that their opinions could be deemed remotely expert and thus would be inadmissible in court. However, the fact that they can self-evidently give weight to their cause is not to be ignored. Similarly, once an expert's evidence is deemed admissible anything he says will go to weight unless specifically excluded by the court.[179] Hence, if a well groomed and articulate professor of diabetology offers that a GP was grossly negligent the jury is unlikely to argue. They are both doctors but their expertise is akin to an international corporate lawyer commenting on the actions of a wills and probate solicitor.

Moses LJ made a number of illuminating comments on the opinions of expert witnesses in his judgment in *Henderson*.[180] Whilst the instant cases concerned shaken baby syndrome his comments regarding expert evidence are apposite.

Firstly, by drawing on the 2004 Kennedy Report, he questions the reliability of expert opinion when drawn from retired clinicians:[181]

> The fact that an expert is in clinical practice at the time he makes his report of significance…Such clinical experience…may provide a far more reliable source of evidence than that provided by those who have ceased to practice their expertise in a continuing clinical setting…Such experts are, usually, engaged only in reviewing the opinions of others. They have lost the opportunity, day by day, to learn and develop from continuing experience. [182]

He also quotes Kennedy by saying '[t]he Kennedy report cautions against doctors using the courtroom to "fly their personal kites or push a theory from the far end of the medical spectrum".[183] It recommends a checklist of matters to be established by the trial judge before expert evidence is admitted.[184]

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[179] Michael Stockdale *Criminal and Civil Evidence* (14th edition, Northumbria Law Press 2013) 380

[180] *R v Henderson; R v Butler; R v Oyediran* [2010] EWCA Crim 1269, [2010] All ER (D) 125 (Jun),

[181] 'Sudden Unexpected Death in Infancy': The report of a working group convened by the Royal College of Pathologists and The Royal College of Paediatrics and Child Health" chaired by Baroness Kennedy QC published in September 2004.Available online: <http://www.rcpath.org/Resources/RCPath/Migrated%20Resources/Documents/S/SUDI%20report%20for%20web.pdf> accessed 1st November 2014.

[182] *R v Henderson; R v Butler; R v Oyediran* [2010] EWCA Crim 1269, [2010] All ER (D) 125 (Jun) [208]

[183] 'Sudden Unexpected Death in Infancy': The report of a working group convened by the Royal College of Pathologists and The Royal College of Paediatrics and Child Health" chaired by Baroness Kennedy QC published in September 2004 [5]

[184] *R v Henderson; R v Butler; R v Oyediran* [2010] EWCA Crim 1269, [2010] All ER (D) 125 (Jun) [207]

Regarding the weight attached to expert evidence, once admitted, he suggests that '[t]he jury are not required to produce reasons for their conclusion. Nevertheless, the judge should guide them by identifying those reasons which would justify either accepting or rejecting any conflicting expert opinion on which either side relies.'[185] Hence, '[a judges] directions are part of the means by which they ensure that a case which depends on expert evidence proceeds to its conclusion on a logically justifiable basis.'[186] Moses' opinions have received widespread support amongst experts themselves.[187]

Quick makes much of the notion that jurors are apt to show deference to medical experts and are therefore in need of advice from the judge.[188] In gross negligence manslaughter cases the questions for the jury are seldom based on technical scientific issues but more on whether the defendant's acts or omissions were so appalling as to merit a criminal conviction. If negligence is not contested then the only matter for the jury is the grossness of the negligence. This is more of a moral question rather than a medical one. In Quick's small study of ten medical expert witnesses he concluded that 'such cases rely heavily on the subjective interpretations and judgements of experts applying their own standards to the cases under review.[189] It doesn't take a huge leap of imagination to picture jurors being swayed one way or the other based on which expert they identify the most with.

Ward offers that the relationship between juror and experts is based on the type of testimony given by the expert. [190] This can either be factual, authoritative or persuasive. The facts in gross negligence manslaughter are usually not contested and the experts are generally authorities. We are left with persuasive testimony; both experts are equal authorities who agree on the facts but draw different conclusions. Hence, they will tend persuade the jurors that their expert inferences are correct. In every sense the experts have decided the

[185] *R v Henderson; R v Butler; R v Oyediran* [2010] EWCA Crim 1269, [2010] All ER (D) 125 (Jun) [220]

[186] *R v Henderson; R v Butler; R v Oyediran* [2010] EWCA Crim 1269, [2010] All ER (D) 125 (Jun) [221]

[187] Jan Miller 'Experts back Moses' [2010] 160 New Law Journal 1658

[188] Oliver Quick 'Expert evidence and medical manslaughter: Vagueness in action' [2011] 38 Journal of Law and Society 496, 501

[189] Oliver Quick 'Expert evidence and medical manslaughter: Vagueness in action' [2011] 38 Journal of Law and Society 496, 516

[190] Tony Ward 'English law's epistemology of expert testimony' [2006] 33(4) Journal of Law and Society 572, 582-593

'ultimate issue' and it is left to the jury, as directed by the judge, to identify with one side's expert(s) or the other. As described by Vidmar 'juries are frequently incapable of critically evaluating expert testimony, are easily confused, give inordinate weight to expert evidence, are awed by science [and] defer to the opinions of unreliable experts' [191]

The relationship between experts and jurors is clearly subject to much controversy. As asserted by Coen and Heffernan, there is 'an urgent need for empirical research involving real jurors in order to gauge jury comprehension of expert evidence, especially in complex cases. [192]

Of course, we should not forget the defendant doctor in all of this. Clearly his testimony and demeanour are also critical when deciding whether a crime has been committed.

5.4 Characteristics of defendant doctors

Quick comments on the 'disproportionate number of non-white practitioners featuring in prosecutions' and speculates on the non-racist reasons for this.[193] However, as one of the prosecutors he interviews says '[t]here's only one [explanation] that occurs to me and it's pure speculation on my part, and that is that people are more willing to complain where the doctors are from a minority ethnic group.'[194] This is given support by the numerous references to racism in the Lawrence report and comments which are readily available on-line regarding non-white doctors.[195] For instance, commenting on the conviction of David Sellu, as reported by the mail online, a member of the public writes 'all contracts issued to foreign doctors who cannot speak fluent English to the proper high standard necessary to practice medicine, should be revoked'.[196] This sentiment may have some merit but given that

[191] N Vidmar *et al* 'Amicus Brief: *Kumho Tire v Carmichael* ' [2000] 24 Law and Human Behaviour 387 [388]

[192] Mark Coen and Liz Heffernan 'Juror comprehension of expert evidence: a reform agenda' [2010] 3 Criminal Law Review 195, 210

[193] Oliver Quick 'Prosecuting 'Gross' Medical Negligence: Manslaughter, Discretion, and the Crown Prosecution Service' [2006] 33 Journal of Law and Society 421, 436

[194] Oliver Quick 'Prosecuting 'Gross' Medical Negligence: Manslaughter, Discretion, and the Crown Prosecution Service' [2006] 33 Journal of Law and Society 421, 436

[195] Numerous forms of racism permeating society are exposed in The Stephen Lawrence Enquiry: Report of an Enquiry by Sir William Macpherson of Cluny [1999]. Online<https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/277111/4262.pdf> accessed 7th November 2014

[196] 'Private surgeon who abandoned dying patient then LIED to inquest is found guilty of gross negligence manslaughter' *Mail online* (comments)

the article simply had the picture of David Sellu (who is black) and made no comment whatsoever about his English language skills gives succour to the notion that non-white doctors, by simply being non-white, are at a disadvantage.

Clearly, it is disingenuous to suggest that racism is rife amongst juries and that this alone is reason enough to dismiss the role of the jury in medical gross negligence manslaughter cases. However, without empirical evidence it is hard to know exactly how juries come to their verdict in such cases. The jurors own experience of doctors and their expectations of them must surely influence the way in which they will perceive the defendant doctor even though, by necessity, they will have never had a doctor-patient relationship with the defendant.

In the light of the above we might concede that experts do not always confine themselves to areas of genuine expertise and are drawn from specialties different from that of the defendant; they are not always faithfully representative of a 'body of medical men skilled in that particular art.'[197] We might also combine this with a notion that potentially biased jurors will place too much emphasis on a retired expert's opinion without having to justify their conclusion. This could amount to an argument against juries in such cases altogether; replaced with a council of more credible experts and guided by a judge with some medical knowledge.

5.5 The fifth ingredient

It is a much easier task to convict if the defendant was not just hopelessly inadequate (feckless) but also evil in some way (reckless, cruel, greedy or deceitful). These additional, subjective components, which are not required in addition to the objective components in gross negligence manslaughter, are evidently relied upon by the Crown Prosecution Service (CPS) when deciding whether to prosecute a case. Griffiths and Sanders go to some lengths to describe this anomaly.[198]

<http://www.dailymail.co.uk/news/article-2487857/Private-surgeon-abandoned-dying-patient-LIED-inquest-guilty-gross-negligence-manslaughter.html#ixzz3IH1IKOVO> accessed 6th November 2014

[197] *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118, [1957] 1 WLR 582 (QB) 587

[198] Danielle Griffiths & Andrew Sanders 'The road to the dock: prosecution decision-making in medical manslaughter cases' in Danielle Griffiths & Andrew Sanders *Bioethics, Medicine and the Criminal Law: Medicine, Crime and Society* (Cambridge University Press 2012) 117 – 158

The CPS was established in 1986 and requires a two stage test as to whether a case should proceed to prosecution.[199] Firstly, there must be sufficient evidence on which to base a realistic prospect of prosecution and secondly, prosecution must be in the public interest.[200] Cases as sensitive and complex as medical manslaughter cases are handled by a subgroup of the CPS, the Special Crime Division (SCD) now amalgamated with the Counter Terrorism Division and known as the Special Crime and Counter Terrorism Division.[201] Griffiths and Sanders state that Article 2 of the European Convention on Human Rights as enacted by the Human Rights Act 1998 means that the CPS are obliged to investigate deaths to a greater extent than they once would.[202] Once confronted with detailed investigative reports the CPS must decide which cases to prosecute.

Griffiths and Sanders looked at seventy five CPS investigations into health care deaths and found that only three cases were actually prosecuted.[203] In twenty cases there were problems in establishing a breach of duty and in thirty three cases causation could not be reliably proved. In thirteen cases the 'grossness' of the negligence was not considered convincing enough to proceed to prosecution. These thirteen cases were remarkable in that the negligence would seem gross (and therefore criminal) as objectively judged by current English law but the prosecutors felt they needed an element of 'badness' to add to the objective elements.[204]

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[199] 'The code for crown prosecutors' 2013 <http://www.cps.gov.uk/publications/docs/code_2013_accessible_english.pdf> accessed 6th November 2013

[200] 'The code for crown prosecutors' 2013 [6 – 10] <http://www.cps.gov.uk/publications/docs/code_2013_accessible_english.pdf> accessed 6th November 2013

[201] The Crown Prosecution Service has a comprehensive website <http://www.cps.gov.uk/> accessed 7th November 2014

[202] Danielle Griffiths & Andrew Sanders 'The road to the dock: prosecution decision-making in medical manslaughter cases' in Danielle Griffiths & Andrew Sanders (eds) *Bioethics, Medicine and the Criminal Law: Medicine, Crime and Society* (Cambridge University Press 2012) 117

[203] Danielle Griffiths & Andrew Sanders 'The road to the dock: prosecution decision-making in medical manslaughter cases' in Danielle Griffiths & Andrew Sanders (eds) *Bioethics, Medicine and the Criminal Law: Medicine, Crime and Society* (Cambridge University Press 2012) 136. A fourth would have been prosecuted had they not fled the country.

[204] Danielle Griffiths & Andrew Sanders 'The road to the dock: prosecution decision-making in medical manslaughter cases'. in Danielle Griffiths & Andrew Sanders (eds) *Bioethics, Medicine and the Criminal Law: Medicine, Crime and Society* (Cambridge University Press 2012) 126

According to Judge LJ, in the face of much academic dissent, '[i]n our judgment the law is clear. The ingredients of the offence have been clearly defined, and the principles decided in the House of Lords in *Adomako*. They involve no uncertainty'[205] If this is the case then how can we explain Quick's study 'show[ing] prosecutorial unease with the fairness of gross negligence, and the reality of prosecutors navigating around the *Adomako* test in search of subjective fault.'? [206]

The CPS cite *Adomako* and describe the four objective tests of gross negligence manslaughter as follows:[207]

a) the existence of a duty of care to the deceased;[208]

b) a breach of that duty of care which;

c) causes (or significantly contributes) to the death of the victim; and

d) the breach should be characterised as gross negligence, and therefore a crime.[209]

This 'fifth element' of 'badness' that the CPS required (be it recklessness, indifference, laziness or deceit) was either not present, the defendants had mitigating circumstances (tired after long shifts), or were simply incompetent rather than deliberate wrong-doers.[210] None of these would seem to be reasons not to go ahead and prosecute on evidential grounds. There seems to have been a merging of evidential and public interest reasoning as to why prosecution should not take place combined with a realistic expectation that a jury would not convict a healthcare professional for being anything other than 'bad'. Fecklessness causing death, whilst criminal in law, is not itself sufficiently culpable for members of the public to deem worthy of gaol.

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[205] *R v Misra, Srivastava* [2004] EWCA Crim 2375 [64]

[206] Oliver Quick 'Prosecuting 'Gross' Medical Negligence: Manslaughter, Discretion, and the Crown Prosecution Service' [2006] 33 Journal of Law and Society 421, 450

[207] Crown Prosecution Service website <http://www.cps.gov.uk/legal/h_to_k/homicide_murder_and_manslaughter/> accessed 5th November 2014

[208] The CPS rely on *Donohue v Stevenson* [1932] UKHL 100

[209] Here the CPS point to *R v Misra, Srivastava* [2004] EWCA Crim 2375 but within their text also refer to *Rowley v DPP* [2003] EWHC 693 (Admin) which introduces subjectivity.

[210] Danielle Griffiths & Andrew Sanders 'The road to the dock: prosecution decision-making in medical manslaughter cases' in Danielle Griffiths & Andrew Sanders (eds) *Bioethics, Medicine and the Criminal Law: Medicine, Crime and Society* (Cambridge University Press 2012) 136 – 145

5.5.1 *Rowley v DPP*

There is scant evidence for the need for a 'fifth ingredient' in case law post-*Adomako* but it is nevertheless relied upon by the CPS.[211] [212] In *Rowley* a seriously handicapped man was in the care of Salford City Council when he was left unattended in a bath and subsequently drowned. The victim's mother brought her case against the Department of Public Prosecution because she felt there was enough evidence of gross negligence to merit a manslaughter prosecution against her son's carer. The CPS' head of the Casework Directorate, Mr Enzor, disagreed. At the High Court Lord Justice Kennedy went to some lengths to analyse Lord Mackay's judgment in *Adomako* outlining the four objective tests that need to be applied. He went on to say:

> It is clear from what Lord Mackay said that there is a fifth ingredient: "criminality" (albeit defining the ingredient in this way "involves an element of circularity") or "badness". Using the word "badness", the jury must be sure that the defendant's conduct was so bad as in all the circumstances to amount "to a criminal act or omission".

Whilst the fifth ingredient may have been clear to Kennedy LJ it has not been clear enough to other judges for them to even mention this fifth element in subsequent cases.[213] [214] Indeed, it was the abandonment of the need to show recklessness in *Adomako* which made it such a landmark case.

However, it doesn't appear to be the presence or absence of recklessness as a point of law that dissuaded the CPS from prosecuting the case. It was more that whatever the law states, it is only persuasive if a jury will accept it as morally right. Mr Enzor in *Rowley* said 'I asked myself the question whether, taking the factors I had identified into account, a properly directed jury would be more likely than not to convict of the offence of gross negligence manslaughter. I concluded that they would not.'[215] This is not an admission that the four objective elements of gross negligence were not sufficiently evidenced but that with those

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[211] *Rowley v DPP* [2003] EWHC 693 (Admin)

[212] This is specifically stated on Crown Prosecution Service website <http://www.cps.gov.uk/legal/h_to_k/homicide_murder_and_manslaughter/> accessed 5th November 2014

[213] *R v Becker* [2000] WL 877688 (CA). In this case the defendant GP inadvertently, and with good intention, administered an overdose of diamorphine which killed the patient. There was no question of 'badness' other than the overdose itself.

[214] A search on Westlaw (6th November 2014) revealed that *Rowley* has only been mentioned in *R v Misra* [2004] EWCA Crim 2375 [56] but is not referred to in any subsequent cases.

[215] *Rowley v DPP* [2003] EWHC 693 (Admin) [53]

elements alone the CPS could not be confident that a jury would convict; a fifth subjective element ensuring the four objective elements would make conviction more likely.

Given that the CPS proceed only when there is a realistic prospect of prosecution, their need for a 'fifth element', something palpably culpable in the defendant's acts or omissions for the jury to grasp, says much about the inadequacy of the objective elements of gross negligence manslaughter. If the CPS prosecutes just three out of seventy five cases of gross negligence manslaughter presented to it and only a third of cases result in successful conviction then the medical profession can sleep well in the knowledge that the chances of killing a patient through negligence is very unlikely to result in a conviction.[216] The discretionary role of the CPS cannot be underestimated. If it is a fact that most gross negligence manslaughter cases never get prosecuted then using reported court cases may give a distorted impression of the scale of the problem of medical manslaughter. Perhaps we have more to learn from Crown prosecutors than we do from the courts when looking at how doctors who kill their patients are managed.

[216] 'In the period between 1986 and 2005, the conviction rate (in terms of the cases that were prosecuted) was 39 per cent.' Oliver Quick 'Prosecuting 'Gross' Medical Negligence: Manslaughter, Discretion, and the Crown Prosecution Service' [2006] 33 Journal of Law and Society 421, 427

6. LEGAL ALTERNATIVES: REGULATORY BODIES, CORPORATE RESPONSIBILITY AND OTHER JURISDICTIONS

In many of the cases we have looked at defendant doctors have relied upon system failures as excuses for their behaviour.[217] Indeed, the CPS consider all the circumstances contributing to the death of a patient and will judge for themselves the merit of any mitigating factors before even prosecuting a case.[218] In the strictest interpretation of the word 'contributory' it is hard to imagine any medical manslaughter case that doesn't involve contributions from other people or organisations. The external inquiry into the death of Wayne Jowett found a plethora of errors contributing to his death, the minority of which were directly attributable to Dr Mulhem.[219] He was convicted of gross negligence manslaughter. The Trust settled with the deceased relatives for a 'substantial sum'.[220]

For an individual doctor to be considered grossly negligent he first needs to be a licensed practitioner and will probably be employed by a health care provider.[221] To be licensed he needs to be registered with the General Medical Council (GMC). We will look at the role of the GMC in licensing doctors and regulating their work and also at health care providers and examine their responsibilities to patients.

6.1 The General Medical Council

The GMC were granted continuing regulatory powers by the Medical Act 1983. Section 1 (1A) states '[t]he main objective of the General Council in exercising their functions is to protect, promote and maintain the health and safety of the public.' In order to do this the

[217] *R v Garg* [2012] EWCA Crim 2520, *R v Misra* [2004] EWCA Crim 2375, *R v Prentice and another; R v Adomako; R v Holloway* [1993] 4 All ER 935 (CA), *R v Becker* [2000] WL 877688 (CA)

[218] Danielle Griffiths & Andrew Sanders 'The road to the dock: prosecution decision-making in medical manslaughter cases' in Danielle Griffiths & Andrew Sanders (eds) *Bioethics, Medicine and the Criminal Law: Medicine, Crime and Society* (Cambridge University Press 2012) 145

[219] Professor Brian Toft 'External Inquiry into the adverse incident that occurred at Queen's Medical Centre, Nottingham, 4th January 2001' Online<http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4082098.pdf> accessed 6th November 2014

[220] BBC News online 'Anger as fatal jab doctor freed' <http://news.bbc.co.uk/1/hi/health/3133076.stm> accessed 6th November 2014

[221] Most doctors are either employed by the NHS or private institutions although it is possible to be entirely independent. This was the case with a plastic surgeon who used his own basement as an operating theatre until discovered by the CQC. *Waghorn v General Medical Council* [2012] EWHC 3427 (Admin), [2013] All ER (D) 95 (Jan)

GMC have powers extending to medical education, registration, licensing, post-graduate training and fitness to practise.[222] Their most recently published guideline, 'Good Medical Practice', gives a detailed description of how doctors should conduct themselves.[223] The four main domains are:

1. Knowledge, skills and performance
2. Safety and quality
3. Communication, partnership and teamwork
4. Maintaining trust

These domains are now rooted in the annual appraisal which all doctors must have. Being able to demonstrate compliance with annual appraisal is key to successful revalidation.[224] [225]. However, it is only recently that the GMC have insisted on this.[226] Until the Bristol Royal Infirmary Inquiry if a doctor maintained his annual subscription to the GMC the only way he could be stopped from practising was by being suspended or erased from the medical register by the GMC Fitness to Practise Panel.[227] [228] However, the Bristol Royal Infirmary Inquiry was published in 2001 to which the Government responded in 2002 with 'Learning from Bristol.[229] Since then we have had the the Shipman Inquiry in which the Inquiry's Chair, Dame Janet Smith, 'criticised the GMC for 'watering down' the original concept of revalidation, sustaining a culture that was not sufficiently patient centred, having procedures that were flawed and overly complex and maintaining too high a standard of proof in order to remove a doctor from practice.'[230] The GMC state that it will take until 2016 to revalidate all

[222] Medical Act 1983 Part 2,3, 3a, 4a, 5 respectively

[223] General Medical Council, *Good Medical Practice* [2013] amended on 29 April 2014 to include 14.1 'You must have the necessary knowledge of the English language to provide a good standard of practice and care in the UK.'

[224] Revalidation on the GMC website <http://www.gmc-uk.org/doctors/revalidation/14193.asp> accessed 6th November 2014

[225] The rules regulating the responsible officer charged with recommending a doctor's revalidation is enshrined in Section 119 of the Health and Social Care Act 2008

[226] The GMCs Licence to Practise and Revalidation Regulations 2012 only came into force in December 2012 and it does not expect all doctors to have revalidated until as late as December 2016

[227] Learning from Bristol: the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 -1995 Command Paper: CM 5207

[228] Fitness to practise decisions were one of the original functions of the GMC as laid out in section 38 of the Medical Act 1983

[229] Learning from Bristol: The DH Response to the Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995 Command Paper: CM 5363

[230] Liam Donaldson 'Good doctors, safer patients' [2006] Department of Health

doctors; it will then have taken over fifteen years to action a fundamental recommendation of an important inquiry.[231] This does little to inspire confidence in a regulator whose role is to protect, promote and maintain the health and safety of the public.

6.2 The Care Quality Commission

Having decided that the GMC is not yet a sufficiently responsive organisation to prevent doctors from being grossly negligent and the two Acts described above are either unwieldy or result in ineffective sanction we are left with the CQC to help improve safety.[232] Given enforcement powers under the Health and Social Care Act 2008 the CQC is to healthcare as a whole what the GMC should be to the medical profession alone. It has made its presence felt by publishing detailed findings as a result of its inspections.[233] The CQC was born out of the Mid-Staffordshire scandal and the subsequent Francis Report which cast doubt on the effectiveness of its forerunner the Health Care Commission.[234] Whether the CQC inspections are frequent enough or go into sufficient detail remains to be seen. Whatever the case, the potential shift from convicting doctors for manslaughter to ensuring that working practices prevent multi-factorial tragedies is welcomed.

6.3 The Corporate Manslaughter and Corporate Homicide Act 2007 (CMCH)

On the face of it the CMCH ought to address our problem of an individual doctor being held solely responsible for a death arising through negligence. Where those errors result from defective management the organisation is to blame. The Act encompasses the elements of duty, gross breach of duty and causation we have seen in gross negligence.[235] It also refers to the way in which the corporations 'activities are managed or organised by its senior management'.[236] Hence, there is no reason to believe that securing a corporate conviction would be any easier than an individual conviction since the hurdles are essentially the same.

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[231] Revalidation on the GMC website <http://www.gmc-uk.org/doctors/revalidation/14193.asp> accessed 6th November 2014

[232] CQC enforcement policy. <http://www.cqc.org.uk/sites/default/files/documents/enforcement_policy_june_2013.pdf> accessed 7th November 2014

[233] Care Quality Commission website <http://www.cqc.org.uk/> accessed 8th November 2014

[234] Robert Francis 'The Mid-Staffordshire NHS Trust public inquiry' in particular recommendation 20 <http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf> accessed 7th November 2014

[235] The Corporate Manslaughter and Corporate Homicide Act 2007 s.1 (1)

[236] The Corporate Manslaughter and Corporate Homicide Act 2007 s.1 (3)

With CMCH there is the additional hurdle of defining 'management' and who represents 'senior management.' Celia Wells doubts the Act will achieve what it sets out to and with no successful convictions against health care organisations to date she has a point.[237] However, if the mere threat of fines and public humiliation is enough to encourage health care organisations to adopt patient-safe systems of work then this is no bad thing. Prior to the CMCH the common law offence of manslaughter by gross negligence would not capture senior management failure.[238] If the senior management at Queens Medical Centre in Nottingham had been under the threat of the Act then perhaps Dr Mulhem would not have been able to kill Wayne Jowett.[239]

6.4 The Health and Safety at Work Act 1974

The section of this Act which concerns us is section 3.[240] In addition we have the Health and Safety Offences Act 2008 which introduces imprisonment for persons convicted under the Act.[241] Here there has been slightly more success in sharing the criminal blame for medical errors. When Dr Misra was convicted for gross negligence manslaughter the employing hospital was subsequently prosecuted and fined £100,000.[242] [243] This was a landmark case and promised to inject some balance to criminal responsibility for manslaughter. However, this not the whole story since the defendant Trust argued that fining it £100,000 would result in safety being compromised rather than augmented. Hence, the fine was reduced to £40,000.

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[237] Celia Wells 'Medical manslaughter: organisational liability' in Danielle Griffiths & Andrew Sanders 'Bioethics, Medicine and the Criminal Law: Medicine, Crime and Society' 2012 Cambridge University Press [208]. See also Neil Allen 'Medical or managerial manslaughter?' in Charles Erin and Suzanne Ost 'The criminal justice system and healthcare' 2007 Oxford [66]

[238] 'It was held that unless an identified individual's conduct, characterisable as gross criminal negligence, can be attributed to the company, the company is not, in the present state of the common law, liable for manslaughter.' Attorney-General's reference (No. 2 of 1999) [2000] QB 796 [815]

[239] Professor Brian Toft 'External Inquiry into the adverse incident that occurred at Queen's Medical Centre, Nottingham, 4th January 2001' Online<http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4082098.pdf> accessed 6th November 2014

[240] 'It shall be the duty of every employer to conduct his undertaking in such a way as to ensure, so far as is reasonably practicable, that persons not in his employment who may be affected thereby are not thereby exposed to risks to their health or safety.' Health and Safety at Work Act 1974 s 3.1

[241] Health and Safety Offences Act 2008. Schedule 3A: failure to discharge a duty to which a person is subject by virtue of section 3 : Penalty on conviction on indictment of up to 2 years imprisonment or fine or both.

[242] *R v Misra* [2004] EWCA Crim 2375

[243] *R v Southampton University Hospitals NHS Trust* [2006] EWCA Crim 2971

As we have examined earlier, punishment is not the only purpose of prosecution; public protection and deterrence also play a part.[244] The public need more protection from very bad health care providers but, paradoxically, these are the providers most likely to be impoverished by fines and consequently pose even more of a danger to the public.

Prosecutions under the Act are likely to continue and at least serve to focus the minds of organisations even if the punishments handed down are somewhat perverse.

6.5 Wilful neglect

An indirect result of the Francis Report (by way of the government's response to it) [245] is the proposed new crime of 'wilful neglect' which moves us from prevention back to punishment. The consultation document published in February 2014 and the government's response in June 2014 quite reasonably pointed out that children and mentally incapacitated people are protected by statute, others are not.[246] [247] There is no equivalent specific offence in relation to adults with full capacity. However, they also acknowledged that 'whilst alternative statutory and common law offences do exist, it is not certain that they could cover every situation that a specific offence of ill-treatment or wilful neglect would.'[248]

The proposed 'duty of candour', which also grew out of the Francis report, started life as a proposal to criminalise individuals for not being candid when patient's were harmed.[249]

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[244] Ashworth & Horder *Principles of Criminal Law* (7th edition, Oxford 2013) 19 and Criminal Justice Act 2003 s.142

[245] 'Hard Truths: The Journey to Putting Patients First'. The Government Response to the Mid Staffordshire NHS Foundation Trust Public Inquiry. Command Paper CM 8777

[246] Department of Health 'New offence of ill-treatment or wilful neglect: Government response to consultation'. <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/319042/Ill-treament_or_wilful_neglect_consultation_response.pdf> accessed 7th November 2014

[247] Children and Young Persons Act 1933 s.1 for children; Mental Capacity Act 2005 s. 44 and Mental Health Act 1983 s.127 for the mentally incapacitated.

[248] Department of Health 'New offence of ill-treatment or wilful neglect: consultation document'. <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/285426/20140226_WN_consultation_doc_-_For_publication.pdf> [8] accessed 7th November 2014

[249] 'Introducing the Statutory Duty of Candour' Department of Health consultation March 2014. <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/295773/Duty_of_Candour_Consultation..pdf> accessed 3rd July 2014

Thankfully, since the consultation this has been diluted and now focuses on organisations rather than individuals.[250] Whether Robert Francis intended his report to result in further criminalising doctors is debatable. Only in proposal 183 does he advocate criminal sanctions against doctors and only then if this is due to dishonesty.[251] The requirement to be honest is embodied in 'Good Medical Practice' paragraph 55. This says '[y]ou must be open and honest with patients if things go wrong.' Paragraph 5 states ''[y]ou must'' is used for an overriding duty or principle' whereas ''[y]ou should' is...used where the duty or principle will not apply in all situations'.[252] There is little room for doubt that being open and honest is a requirement and not an option. Unfortunately, as we have seen, the GMC still only possess teeth if doctors are referred to them. Until revalidation is robustly policed we will continue to rely on alternative legislation to root out doctors liable to be grossly negligent.

6.6 Other jurisdictions

Medical manslaughter is not a uniquely English problem. Hence, it is reasonable to review how other countries deal with reckless and feckless doctors. Similarly, just because the English process of law might suit one crime it may not best fit another. It could be that gross negligence manslaughter as applied to doctors needs a different arena to that which pertains currently. We have already looked briefly at New Zealand and its flirtation with the criminalisation of negligence causing death and found that it now operates in a similar way to England.

6.6.1 France

The French system of law regarding doctors who are accused of harming patients negligently is inquisitorial.[253] Instead of prosecution and defence appointing experts and preparing their respective cases for trial, the French have a *juge d'instruction* (JI) who instructs experts to advise her ahead of any trial. In addition she liaises closely with

[250] The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 s.20

[251] Robert Francis 'The Mid-Staffordshire NHS Trust public inquiry' recommendation 183 <http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf> accessed 7th November 2014

[252] General Medical Council, *Good Medical Practice* [2013] Available online at http://www.gmc-uk.org/static/documents/content/Good_medical_practice_-_English_0414.pdf> accessed 23rd June 2014

[253] Melinee Kazarian 'Criminal responsibility for medical malpractice in France' [2011] 27(4) Professional Negligence 188

either victims or the relatives of victims.[254] Experts are therefore 'court appointed' and the victims state their grievances directly. A notable other difference is that negligence falling short of death ('simple negligence') can also be criminal and thus punishable by imprisonment or fine.[255] This goes some way towards reconciling the anomaly that in England recklessness causing harm, short of death, in a medical context, is managed through the civil route; [256] [257] the miscreant doctor only being punishable by GMC or employer sanction. Furthermore, the French can sentence a doctor to one year's imprisonment for 'an act or omission in cases where there was 'direct exposure of another person to an immediate risk of death or injury likely to cause mutilation or permanent disability by the manifestly deliberate violation of a specific obligation of safety or prudence imposed by any statute or regulation'.'[258] The French, therefore, criminalise substandard care both risking death or harm and causing death or harm. Many more of the seventy five cases analysed by Griffiths and Sanders would have been prosecuted had they occurred in France.[259]

6.6.2 Australia

The Australian system adds further complication to any simplistic idea that the English have it all wrong and it's much better elsewhere. In Australia there are essentially two systems of law depending on the State in which a transgression occurs. The common law States and 'Code' States effectively legislate against gross negligence manslaughter

[254] Melinee Kazarian 'Criminal responsibility for medical malpractice in France' [2011] 27(4) Professional Negligence 188, 195

[255] Melinee Kazarian 'Criminal responsibility for medical malpractice in France' [2011] 27(4) Professional Negligence 188, 193

[256] An anomaly outlined by M Brazier and N Allen 'Criminalising Medical Malpractice' in Charles Erin & Suzanne Ost (eds) *The criminal justice system and healthcare* (Oxford 2007) 17 and Michael Jefferson 'Offences against the Person: Into the 21st Century' [2012] 76 Journal of Criminal Law 472 amongst many others.

[257] In *Kay's Tutor v Ayrshire and Arran Health Board* [1987] 2 All ER 417 (HL) the fact that substandard care was clearly evident it could not be deemed either criminal or negligent since it was not the cause of the harm.

[258] 223-1 *Code Pénal*.as described and translated by Melinee Kazarian 'Criminal responsibility for medical malpractice in France' [2011] 27(4) Professional Negligence 188, 194. The *Code Pénal* is available <http://www.legifrance.gouv.fr/affichCode.do?cidTexte=LEGITEXT000006070719> accessed 11th November 2014

[259] Danielle Griffiths & Andrew Sanders 'The road to the dock: prosecution decision-making in medical manslaughter cases' in Danielle Griffiths & Andrew Sanders (eds) *Bioethics, Medicine and the Criminal Law: Medicine, Crime and Society* (Cambridge University Press 2012).

and gross negligence harm.[260] [261] Provided the doctor has acted in good faith then a conviction is unlikely; recklessness or intent is required.[262] To this extent they have what many commentators feel is necessary in English law; to punish only reckless doctors but to include those who harm as well as kill.

Is the French system better than ours? Naturally, there are problems with the French system too. One of the complaints is that a purely civil action in France is very expensive for the claimant. If he or she can join their civil complaint to a criminal investigation there is no charge.[263] This goes some way to explaining the greater number of criminal doctors in France who naturally fear being prosecuted for simple errors. There is also criticism of the idea of court appointed experts.[264] Howard asserts that 'the accusatorial system copes with bias on the part of experts much better than the inquisitorial' and that '[a] judge summing up to a jury would be bound in effect to adopt the experts' report and the jury to rubber stamp it.' [265] It might be true that the accusatorial system copes well with bias but it is surely done away with altogether if the court rather than the sponsoring adversary appoints the experts. Similarly, the argument that court appointed experts effectively decide the ultimate issue is hardly different to the current system. Howard's lively assertion that court-appointed experts would produce a new set of problems worse than any we have under the present system is hotly disputed by Spencer. He argues that the adversarial system distorts the evidence of experts and court appointed experts would be cheaper and of a higher quality.[266] Given that this debate was published over twenty years ago and the only recent small concessions to Spencer's concerns regarding expert witnesses have been the 2014 Criminal Procedure Rules, the removal

[260] The Common Law prevails in New South Wales, Australian Capital Territory, South Australia and Victoria whereas Queensland, Western Australia, Tasmania and Northern Territories operate their own criminal codes (statute) eg: The Queensland Criminal Code.

[261] Ian Dobinson 'Doctors who kill and harm their patients: the Australian experience' in Danielle Griffiths & Andrew Sanders (eds) *Bioethics, Medicine and the Criminal Law: Medicine, Crime and Society* (Cambridge University Press 2012) 248

[262] The leading case is *R v Nydam* [1977] VR 430 which applied *R v Callaghan* [1952] HCA 55 which in turn relied heavily on Lord Atkin's judgement in *Andrews*

[263] Melinee Kazarian 'Criminal responsibility for medical malpractice in France' [2011] 27(4) Professional Negligence 188, 195

[264] MN Howard 'The neutral expert: a plausible threat to justice' [1991] 57(3) Arbitration 186

[265] MN Howard 'The neutral expert: a plausible threat to justice' [1991] 57(3) Arbitration 186, 189-190

[266] JR Spencer 'The neutral expert - an implausible bogey' [1991] 57(3) Arbitration 191

of expert immunity in *Jones v Kaney* and Moses LJ's comprehensive review in *Henderson*, Howard's contentions would seem to have the upper hand.[267] [268] [269]

The Australian system would seem to offer an alternative that stops short of dispensing with the adversarial system. However, the conviction rate there is even lower than in England and very few doctors ever get punished for harming their patients.[270] This might suggest that Australian doctors are better than their English counter parts but it probably suggests that the culture in Australia is still one of deference to doctors.

[267] Criminal Procedure Rules 2014. SI 2014 1610

[268] *Jones V Kaney* [2011] UKSC 13, [2011] All ER (D) (Mar)

[269] *R v Henderson; R v Butler; R v Oyediran* [2010] EWCA Crim 1269, [2010] All ER (D) 125 (Jun),

[270] Of 18,000 avoidable deaths due to medical adverse events there were only a handful of prosecutions. Ian Dobinson 'Doctors who kill and harm their patients: the Australian experience' in Danielle Griffiths & Andrew Sanders (eds) *Bioethics, Medicine and the Criminal Law: Medicine, Crime and Society* (Cambridge University Press 2012) 249

7. CONCLUSION

If we begin with the premise that all doctors are human we can accept that they harbour human attitudes which may be reflected in their behaviour; the virtuous as well as the contemptible. Being 'professional' helps to provide a filter through which the evil traits struggle to pass but clearly some still do. Hence, doctors need to be regulated and held to account when they fail in their duties. The criminal law becomes involved when a doctor's detraction from their duty has offended the state to the extent that punishment is deemed appropriate. The basis for attributing culpability must have an ethical basis and the mechanism by which the law asserts its authority must be both sufficiently sensitive and specific. Ideally, all criminal doctors will be brought to justice (high sensitivity) and no innocent doctors will be punished (high specificity).

As we have seen the reality is both a failure of ethics and mechanics. Sensitivity is low; too many reckless doctors do not get punished until they kill. Specificity is high; but this is to be expected if only one or two convictions per year come from a pool of over a quarter of a million doctors. With so few doctors reaching the dock specificity should be almost one hundred percent; there is no excuse for wrongful convictions such as *Prentice and Sullman*.

The proper ethical basis of gross negligence manslaughter is recklessness. The feckless doctor, manifesting his ignorance through inadvertence is not a criminal; worthy of instant removal from service, of course, but not imprisonable. The feckless doctor is a product of either poor regulation or poor management. The reckless doctor, aware of his risk taking or by being indifferent to those risks is allowed to prosper because of poor regulation or bad management. However, he cannot be allowed to rely on this as an excuse for his own culpable attitudes. He is a criminal and should be treated as such; not only if he kills but also if he harms or shows tendencies towards harming. We have much to learn from the French in this respect.

Where an environment has provided the stage for acts and omissions leading to patient harm, it is only right that it is scrutinised, interrogated and changed. The GMC has still not relicensed all of its doctors over a decade after it was told to. Whether self-regulation continues to be a suitable tool for keeping doctors in check is highly debatable. The events at Alder Hey, Bristol and North Staffordshire suggest otherwise. The need for duplicate

legislation on candour and wilful neglect adds further weight to the notion that medical self-regulation, as championed by the GMC, is in need of radical reform.

Doctors are usually employees and so employers cannot claim to be innocent bystanders when their patients suffer morbidity or mortality. The Corporate Manslaughter and Corporate Homicide Act is unlikely to provide the teeth required to nurture patient-oriented doctors. There is some scope with existing Health and Safety legislation to pressure Trusts into safer practices but this is usually a *post hoc* exercise and not always prophylactic against harm in the first place. Likewise, Coroners can order Trusts to take measures to prevent future harm but cannot intercept harm until a death has occurred. Perhaps the greatest hope for providing a patient-safe hospital staffed by competent and caring doctors comes from the Care Quality Commission. If the GMC cannot reliably regulate doctors at least if the CQC might make their working environment hostile to recklessness.

As far as the mechanics of a successful conviction for gross negligence manslaughter is concerned, the lessons we have from the scant information available from the CPS suggests what is reported in law reports and journals is the tip of a large iceberg. With the majority of cases never reaching the courts and a minority of those that do resulting in conviction, gross negligence manslaughter fails mechanically as well as ethically. The CPS view the objective elements of *Adomako* as the starting point for a conviction but insist on the subjective elements espoused in *Rowley* to proceed. This is a realistic stance but not actually the law.

All cases reaching the CPS are worthy of scrutiny and a clear conclusion that can be broadcast to properly interested parties. It matters far more that lessons are learned than convictions are gained. If there are no lessons to learn from *Sellu* other than to carry on as normal but with fingers crossed then it is chilling to imagine the medical inertia generated by cases that do not even get prosecuted. The unsatisfactory performance of the GMC and the medical profession's continued unwillingness to learn from the mistakes of its brethren engenders little sympathy from the public and makes further convictions inevitable.

English criminal law should confine its convictions for medical manslaughter to culpable doctors and broaden its scope to include non-fatal harm. It should prosecute those with a *mens rea* most people can understand and identify as contemptible without the need to rely so heavily on highly subjective and, occasionally very poor, expert witness testimony.

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9. GLOSSARY

Cephaloversion. This describes the act of trying to turn a foetus in the womb by manipulating the woman's abdomen. It is usually used to turn a baby from breach (head-up) to cephalic (head down). In 1924 it would have been a technique employed far more commonly than today.

A normal anaesthetic would include **cannulation** (insertion of a thin tube into a vein), **induction** (injection of anaesthetic into the tube) and **paralysis** (injection of a muscle relaxant).

Fentanyl is a short acting morphine-like substance that reduces pain but also causes some sedation. **Midazolam** causes sedation but no pain relief. The two are very commonly used in anaesthesia either together or singly.

Diabetic Ketoacidosis. In its untreated form, type 1 diabetes mellitus results in a high blood level of circulating glucose which causes dehydration through excess urine production. Without insulin the glucose cannot enter brain cells and so patients become drowsy and eventually comatose. Similarly, because the body cannot use the circulating glucose it burns fats instead which results in a high blood and breath level of keto-acids. Keto-acids smell like pear-drops to some people. It is an easy diagnosis to make if the doctor knows the patient is diabetic. If this is the first presentation the signs and symptoms may be initially confused with a whole range of other diseases.

Air embolism. Rather like having air in a hot water system, being far more compressible than water, the pump cannot push it around the radiators and the system fails. By the same mechanism, if air gets into the blood circulation it can cause sudden heart failure Tiny amounts of air are sometimes deliberately injected since the contrast with blood, as seen on ultrasound, can reveal tiny holes in the heart which would be otherwise invisible. This is called a bubble-test.