**Medical Defence Union submission**

**Professor Sir Norman Williams Review into gross negligence manslaughter in healthcare**

**Background**

1. The MDU is a mutual, non-profit making organisation providing medico-legal benefits to members who are principally doctors working in the UK. Members can seek our advice and assistance with criminal investigations and procedures arising from their clinical practice and that includes investigations after patients have died unexpectedly. Within the MDU’s in-house legal department we have a team of four lawyers specialising in criminal law who have over 70 years’ experience between them and who assist our members with criminal investigations arising from their clinical practice. This includes investigations for gross negligence manslaughter (GNM). I have acted for over 100 MDU members who have been investigated, and represented doctors charged with manslaughter in 10 cases.
2. Our submission to this review is based on our experience of this area of law which is derived largely from assisting doctors, though we have also assisted dental members with GNM investigations. Our submission is in three parts:
* General comments on the effect of GNM investigations on practitioners, employers and regulators
* Legal background describing how the offence of GNM is applied to doctors
* Recommendations for changes to the procedure
1. While we do not rule out the potential for legal change, we recognise it is not part of the GNM Review’s remit to consider it. We also believe it would be difficult to achieve any time soon given the current political climate and the practical impossibility of getting any new legislation before parliament. In addition, changes to legislation are always an uncertain and invariably lengthy process – two years or more - and, given the clear distress that GNM investigations cause for doctors who are subject to them, and the fear and concern this generates more widely among healthcare practitioners, we urge swifter and more decisive action. There is an urgent need to improve the speed of the process and decision-making which would benefit healthcare professionals as it would the families of the deceased. The changes we are advocating are straightforward and do not have many practical difficulties in implementation, though they are to an extent dependent on the will of those who have the power to make them.

**The effect of GNM investigations on practitioners, employers and regulators**

1. Too many doctors in England are investigated and prosecuted for GNM. Since 2014 the MDU has assisted 34 members with GNM investigations. In 27 of those cases medical members were assisted by the MDU’s in-house legal team of specialist criminal lawyers. There should be far fewer investigations and prosecutions of healthcare practitioners for GNM. The public interest lies in identifying and prosecuting only those cases that are the medical equivalent of deliberately driving down the motorway on the wrong side. In Scotland we know of no case where a doctor has been prosecuted for the similar offence of culpable homicide. While the Scottish offence is strictly different from GNM, in practice it would be likely to amount to a significantly similar threshold. However, there are few investigations and, as far as we know, there have been no prosecutions of doctors in the context of healthcare provision. We believe the same policy approach should apply in England and that investigation and prosecution of healthcare practitioners should be reserved for only the worst cases.

**The police, NHS bodies and NHS Improvement**

1. It should be recognised by all that an investigation by no means implies someone is guilty of an offence. No offence may have been committed at all. Some trusts are supportive of doctors under investigation for GNM, and some police officers recognise and take account of the distress these investigations bring. However, some trusts may appear more concerned for their own position, and some lack experience or competence to assist staff involved. On occasion too there is an appetite for investigation on the part of the police that makes the process more adversarial than it needs to be.
2. The police investigation process is guided by an annex to the *Murder Manual*, which contains guidance to officers. The MDU was provided with the first version of this on a private basis, but subsequent versions have not been made available to us. In its original form, the annex contained guidance which recognised the distress that doctors can experience during such investigations. The application of the guidance seems patchy. We would welcome openness on the part of the police in disclosing the content of the annex, and a proper recognition in it and through it of the significant stress such investigations cause.
3. While trusts and the GMC generally stay their procedures until the criminal investigation is over, doctors are almost always restricted in their work by their employers and may be allowed only to undertake non clinical work. The GMC, having learnt of an investigation for GNM, will frequently refer doctors to an interim tribunal (formerly panel) which makes an order almost invariably imposing conditions on registration which are likely to last for the duration of the criminal investigation, and often longer. Regrettably the approach taken by the GMC and tribunals is that the mere fact of a police investigation, with a doctor deemed a suspect, means that public confidence in the profession can only be sustained by taking action on that doctor’s registration. We think this is simplistic and unfair.
4. In addition there can be trial by media. Many GNM cases attract intense media scrutiny of the doctor which can be intrusive and in high profile cases it can extend to his or her family. While some NHS trusts behave impeccably towards doctors under investigation and are scrupulous about liaison with the doctor’s defence team and careful about what information is given to the media and whether they refer publicly to the part any doctor may or may not have played, this approach is not universal. It is a matter of regret that on occasion some trusts display a greater concern for their own position, perhaps influenced by the existence of an offence of corporate manslaughter, than the need to ensure that individual employees caught up in a police investigative process are supported fully and properly.
5. There has been evidence provided elsewhere, for example in the Department of Health’s 2016 consultation on safe spaces, about the toxic environment in which some doctors practise. We understand there is a will to change this and there are proposals for improving and standardising the investigation process which may assist doctors, especially in respect of serious patient safety incidents more generally. However, the NHS is far from being a ‘just culture’ and this submission is concerned with steps that can be taken to improve the process for clinicians specifically in relation to unexpected deaths.
6. NHS Improvement has [a webpage](https://improvement.nhs.uk/resources/learning-deaths-nhs/) containing guidance and policies for trusts to assist them to improve their processes for learning from deaths. There are numerous documents and many of them, quite rightly, [highlight the importance of ensuring those who are bereaved are treated sensitively](https://improvement.nhs.uk/resources/learning-deaths-nhs/#h2-national-guidance-on-learning-from-deaths) and provided with all appropriate support and information. Notably absent is any detail about how these events may affect clinicians, or guidance explaining the effect that sudden unexpected deaths have on the clinical team or requiring them to be treated in a fair way, without blame and with respect for their rights.
7. We recommend that, as a priority, NHS Improvement should be required to review all material setting out requirements for or providing guidance on dealing with and learning from sudden unexpected deaths. It should ensure any material that does not already do so emphasises that it is equally important for NHS bodies to treat healthcare staff involved in these incidents in a fair and supportive manner and to steer clear of premature apportionment of blame. Healthcare practitioners must be held accountable, but only after due and fair process.
8. We also recommend that the GMC be asked to take a look at its referral protocols for cases involving investigations for GNM. We have explained above that GNM cases are over-investigated and we outline later in this submission proposals to address this, but we believe the GMC, and other healthcare professional regulators, should also be required to take a look at their referral procedures as a matter of urgency. Is referral to an interim tribunal really the only option when they know that the great majority of investigations are discontinued and that, ultimately there are no regulatory findings or sanctions? Looking at cases where doctors have been suspended as a result of their involvement in GNM investigations which then came to nought, is it not possible for regulators to identify factors that could indicate a different and more proportionate approach? The GMC has acknowledged in the last few years that most single clinical incidents are unlikely to amount to impaired fitness to practise and such cases are now generally referred to its provisional enquiry procedure. We believe it should look at GNM cases, which are invariably single clinical incidents, in a similar way. We are not suggesting they should be preliminary enquiries, but that the GMC should satisfy itself that the approach it takes to such cases is consistently proportionate and fair.

**Gross negligence manslaughter - legal background**

1. The present formulation of the offence of gross negligence manslaughter (GNM) is found in the House of Lords case of *R –v- Adomako* (1994). To establish an offence, it is necessary for the prosecution to show the following:
2. The existence of a duty of care;
3. Breach of that duty involving an obvious and serious risk of death;
4. The breach of that duty was a material contribution to the hastening of the death;
5. The negligence established from i-iii was so bad as to be considered gross and thus a criminal offence.
6. Difficulty has arisen in formulating an explanation of how bad the negligence of a defendant has to be to establish criminality as the fourth part of the test. The decision in *Adomako* did not provide a model which could be adopted by a judge in describing that concept as part of a direction of law to a jury.
7. Lord Mackay in giving judgement in *Adomako* stated the assessment of whether or not something is so bad as to amount to a crime is very much an issue for the jury:
	1. ‘*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…a risk of death to the patient, was such that it should be judged criminal’.*
	2. *‘The essence of the matter which is supremely a Jury question is whether having regard to the risk of death involved, the conduct of the Defendant was so bad in all the circumstances as to amount in their judgement to a criminal act or omission’.*
8. In a non-medical case – *R –v- Litchfield* (1997), the Court of Appeal approved the trial judge’s direction to the jury as essentially consistent with *Adomako* where he included the following comments to the jury in his directions:
	1. *‘Before you could convict this defendant of manslaughter, the negligence established must …. go way beyond the mere matter of compensation between parties. It must be more than just some degree of fault, or mistake, or error of judgment, or carelessness, even though that led to death. It must be such as to demonstrate a reckless disregard for the lives of others of such a nature, and to such an extent, that in your judgment the negligence is so bad that it can properly amount to a criminal act. You will not, by a verdict of guilty, categorise the defendant’s conduct as grossly negligent unless each one of you is sure that his conduct was so bad, so obviously wrong, so reckless, that, having regard to the risk of death involved, it can properly be condemned as criminal, not in some technical sense of the word, like somebody might be regarded as criminal if they did not have a light on the back of their bicycle, but in the ordinary language of men and women of the world….’*
	2. *‘What must be proved is negligence that shows ….. a reckless disregard for the lives of others, of such a nature, and to such an extent, that in your judgment the*
	3. *negligence is so bad, in all the circumstances, that it amounts to a criminal act or omission .... The negligence must be so bad, so obviously wrong, so reckless, that having regard to the risk of death involved, you are sure the conduct must be condemned as criminal and thus, of course, requiring punishment of the criminal by the State’.*
9. The apparent flexibility, however, allowed the trial judge in the case of *R v Becker* to direct a jury that to convict they had to find the negligence criminal (stated 4 times), and that mistakes come in all shapes and sizes. No reference was even made to civil negligence as a comparison. The Court of Appeal dismissed Dr Becker’s appeal, saying this direction too was consistent with Adomako.
10. In the subsequent medical GNM case of *R –v- Mizra* *and Srivastava* (2004), the trial Judge directed the jury in the following terms:
	1. *‘… duty and breach of duty - … will be the starting point to establish civil liability to pay damages. But as you would expect, and is the law, the prosecution must make you sure of something much more, and much more serious, than that before a person can be convicted of the crime of manslaughter…. Mistakes, even very serious mistakes, and errors of judgment, even very serious errors of judgment, and the like, are nowhere near enough for a crime as serious as manslaughter to be committed. If you do conclude that you are sure that either or both of the defendants have been in breach of their duty of care in their treatment ….you must therefore go on to consider the nature of that carelessness or negligence, as you find it to be. Over the years, the courts have used a number of expressions to describe this vital element of the crime, but the key is that it must be gross in the perhaps slightly old-fashioned sense now of the use of that word. So in this case, when you are considering the conduct of each doctor, I think you will find it most helpful to concentrate on whether or not the prosecution has made you sure that the conduct of whichever one you are considering in all the circumstances you have heard about and as you find them to be, fell so far below the standard to be expected of a reasonably competent and careful senior house officer that it was something, in your assessment, truly exceptionally bad, and which showed such an indifference to an obviously serious risk to the life of Sean Phillips and such a departure from the standard to be expected as to amount, in your judgment, to a criminal act or omission, and so to be the very serious crime of manslaughter.’*
11. The Court of Appeal subsequently described that summing up as *‘fair and balanced’.*
12. Until recently, therefore, the nature of the description which a judge might employ in directing a jury on that fourth element was unacceptably uncertain. It could permit the unfair approach taken in the case of Dr Becker, through to the more sensible and appropriately descriptive approaches in Litchfield and Misra. Both Litchfield and Misra have subsequently been used in formulating directions to juries in medical GNM cases (including the case of Dr X below).
13. Fortunately, the degree of uncertainty has in some significant measure been removed through the case of *R v Sellu*. The Court of Appeal referred to the directions in Misra and the case of a ‘Dr [X]’ (which had combined something of the approaches in Misra and Litchfield). The Court of Appeal made clear that no particular formulation is mandatory, but stated:
	1. *‘…what is mandatory is that the jury are assisted sufficiently to understand how to approach their task of identifying the line that separates even serious or very serious mistakes or lapses, from conduct which, to use the phrase from the above direction, was "truly exceptionally bad and was such a departure from that standard [of a reasonably competent doctor] that it consequently amounted to being criminal."’*
14. The direction given to the jury in the case of Mr Sellu was insufficient. The result is that while there is no strict prescribed formula, the approach taken by a trial judge in describing the degree of criminal culpability in reality must be consistent with the approach in Misra, Dr X or Litchfield.
15. In addition, the cases of *R v Rudling* and *R v Rose* have helped establish that the obvious and serious risk of death must be apparent to a reasonably prudent person in the position of the defendant - obvious at the time of the breach, and not if the breach had not occurred.
16. Again, we appreciate that it is not part of the panel’s remit to consider legislative change in relation to the law concerning GNM. It may be felt that position is unsatisfactory, and we can see for example that the formulation in Litchfield, referring to ‘recklessness’ is not to be found in the same way in Misra. Nonetheless, it is open to a judge to use the word ‘reckless’ in an appropriate case as a descriptor of potentially culpable conduct.
17. In summary, however, the law as it stands today is better than in recent times in terms of providing clarity about how a jury might be properly directed.

**MDU recommendations for changes to the procedure for investigation and prosecution of GNM**

**The process**

The incidence of investigation

1. There are many more investigations than there are prosecutions. While prosecutions have an obvious deleterious effect so too can the threat of prosecution which arises through the investigation process. Investigations cause a ripple beyond those immediately caught up in a case. For the individuals, there is significant distress, and over an excessive period. Doctors are usually restricted in practice by virtue of the investigation which will frequently trigger GMC investigation.

The incidence of investigation to prosecution

1. At a lecture 3 years ago a specialist prosecutor from CPS Special Crime indicated that in healthcare cases generally the incidence of non-prosecution was of the order of 95%.That accords with the MDU’s perception – at fewer than 1 prosecution in 10 investigations. That represents a significant level of over-investigation which has a deleterious effect on all those involved, with resource implications for the police and potentially for healthcare providers.
2. In our experience most cases are referred to the police for investigation by coroners. It is right a coroner does not hold an inquest where that might prejudice the right to a fair trial, and plainly the number of investigations will always be greater that prosecutions. However, a 10:1 ratio is excessive and of great concern.
3. We suggest 2 approaches that should be considered together:
	1. All cases should be referred through or only after consultation with the Chief Coroner. That would mean someone with comparators and in a senior position would be able to filter cases. It would have the advantage of establishing consistency, which is plainly not evident at present.
	2. Coroners should be given a full and proper explanation of the law to enable them to assess cases in the first place. This is absent from the Chief Coroner’s [first law note on homicide](https://www.judiciary.gov.uk/wp-content/uploads/2016/02/law-sheets-no-1-unlawful-killing.pdf). The section on GNM is contained in only 6 paragraphs of information which is out-of-date and arguably inaccurate. Missing from it, for example, is any detailed reference to the Misra type direction, which is necessary to understand just how high the bar is for wrongdoing to come close to criminality.

**Time taken to investigate**

1. The effect of the investigation is made worse by the fact that it takes so long. I routinely advise that a case will last 6 months, and often more than a year. Two recent investigations which closed lasted in the order of 18 and 20 months respectively. My worst experience is in excess of 3 years from interview to prosecution decision.
2. The delay affects those under investigation and their colleagues and has far wider repercussions. Lengthy investigations also affect the deceased’s family who may have to wait for a very extended period before a non-prosecution decision is reached and the case can then proceed to inquest. It is only at the inquest that the family properly hears the evidence for the first time. One MDU member’s case concluded last year with an inquest starting 6 years and 10 months after the death. It was apparent that this resulted at least in part from a lack of explanation to a key expert of what amounts to GNM. This cannot be acceptable for anyone involved in the process. The solutions could be as follows:
	1. Formation of a national police unit to investigate GNM. The benefit would be that with experience should come greater speed and the knowledge to sort wheat from chaff in clinical cases that are invariably complex.
	2. In the event of reluctance to create a national approach, regional specialist units could be established to the same end.
	3. Revise the explanation of the law on GNM in the [Senior Investigating Officer’s (SIO) Guide](http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwiIh8Gh6OnZAhVGSsAKHUvnAQUQFggpMAA&url=http%3A%2F%2Flibrary.college.police.uk%2Fdocs%2FNPCC%2F2015-SIO-Guide-Investigating-Deaths-and-Serious-Harm-in-Healthcare-Settings-v10-6.pdf&usg=AOvVaw0pbyoNrKFX6qXdGcBx4ouP). The version which appears to be available at present does not make clear the very high threshold before an unexpected patient death can be considered criminal. A better explanation of the law may enable SIOs to establish more quickly those cases which will not meet the threshold.
	4. We believe the police should be more strongly encouraged to consider early instruction of medical advisers, with the hope that such advisers may assist the police to sort ‘wheat from chaff’ early on.
	5. The police should be required to work in liaison with the Special Crime and Counter Terrorism Division of the Criminal Prosecution Service (CPS) from an early stage. At the moment this is encouraged, but it should be the default position, given Special Crime has expertise in reviewing these complex cases.
	6. Police forces/national crime agency should be strongly encouraged to seek input from (non-medical) experts in the field.
	7. CPS should have a greater resource within the Special Crime Division.

**The prosecution decision – getting the right cases**

1. CPS national success rate in securing convictions overall runs at just under 80%. Analysis of GNM cases over recent years suggests the CPS secure convictions in about one-third of cases. They are not getting GNM right – and that is further demonstrated by the failure rate on appeal of late.
2. Prosecution should be reserved for only the worst cases. The MDU believes the public interest lies in identifying and prosecuting only those cases that are the medical equivalent of deliberately driving down the motorway on the wrong side.
3. Solutions may include:

Mandatory human factors training for those involved in the prosecution process for GNM

1. There is a danger that ‘reckless’ behaviour may be seen in a very technical sense – to the degree that it is perceived that any departure from the ‘straight and narrow’ in medicine involves a potential significant risk.
2. Such training could lead to a better understanding of how multiple factors (which often exist in clinical situations) such as the effect of a poorly functioning system and the errors of others can combine and affect the behaviour of a given individual. That may help those involved in the prosecution process to assess if there is any real criminal culpability on the part of the healthcare practitioner.

Getting the right expert guidance

1. Easy to say, but the solution is more difficult. It is fundamental that those seeking opinions in this area do so with the aim and desire of securing independent expert guidance to provide an objective view, not to support their own position.
2. The police need to provide clear explanations to experts so they understand their function. For example, the letter of instruction must make it plain experts are expected to have a truly fair and impartial approach, with the duty owed to a court – not the police. It is not clear to us that within existing police guidance there is any requirement to stress to the expert the need for an impartial objective opinion, nor reference to the criminal procedure rules (which do that). This should be required as a fundamental part of the instructions.
3. Although we understand police guidance indicates the need for the expert to have an understanding of the terms of criminal gross negligence and a gross breach of a duty of care it is deficient in its explanation of the law to the police. This emphasises our point above, that it is essential that the police who are investigating GNM cases need a clear understanding of the law.
4. As part of proper instruction of experts, we believe it would be appropriate for there to be a common statement of the law to be given to experts by all relevant parties. This should include CPS, the police and those acting for the healthcare practitioners. We have previous recommended this approach, but we are not aware that it has been taken further by CPS.

Willingness to engage with the defence

1. In our experience CPS is reluctant to engage with the doctor’s lawyer even if those lawyers have considerable experience. CPS should be mindful of the impact on the doctor and the family of such delay, and take all necessary steps, including engaging appropriately with those acting for healthcare practitioners, to reach a decision as soon as possible.

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