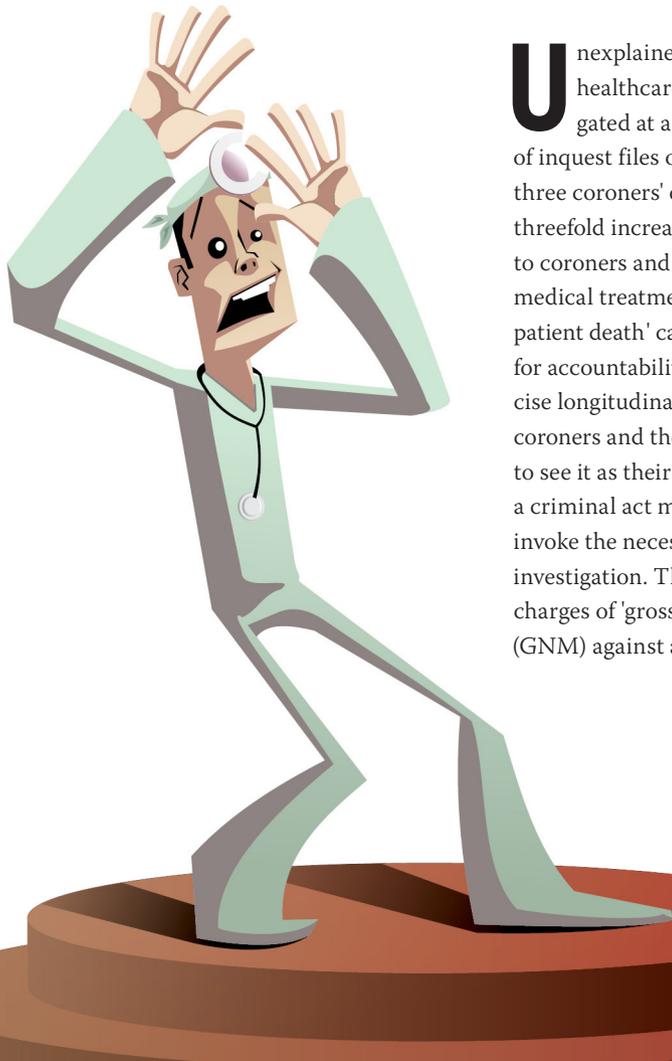


Gross negligence manslaughter and the healthcare professional

Jenny Vaughan looks at the escalating trend of criminal investigation into healthcare-related deaths in England and Wales and asks: did we see this coming?



Unexplained and unexpected deaths in healthcare are increasingly investigated at a coroner's inquest. Analysis of inquest files over a ten-year period from three coroners' offices has demonstrated a threefold increase in complaints by relatives to coroners and the police about standards of medical treatment.¹ A potentially 'avoidable patient death' can be associated with a search for accountability by relatives. Although precise longitudinal data is hard to obtain, both coroners and the police are now more likely to see it as their duty to consider whether a criminal act may have taken place and invoke the necessary steps to allow further investigation. This process can include laying charges of 'gross negligence manslaughter' (GNM) against any number of healthcare

professionals involved in a patient's death. The precise reasons for these developments are unclear. They are thought to include the aftermath of Shipman and the fact that the Crown Prosecution Service (CPS) treats these cases very differently to most other criminal cases and has specialist units set up to assist. Very recent successful prosecutions may have provided more of a 'template' for how to handle other cases. Overall, it is still too early to tell.

IT COULD HAPPEN TO ANYONE

Despite the small numbers, medical manslaughter cases attract considerable publicity: a single successful prosecution can have significant ramifications for medical practitioners. Table 1 shows data from media reports over the past year, illustrating that an unprecedented array of health professionals now face criminal charges. Most doctors accept the burden of civil litigation and are indemnified appropriately, but the possibility of increasing criminalisation should be taken very seriously. Ken Woodburn, a consultant vascular surgeon, recently described his own experience when he was accused and then

acquitted of the manslaughter of a patient.² His most potent observation was that 'we are all only one error away from potential criminal prosecution.'

GROSS NEGLIGENCE AND RECKLESSNESS

The decision by police to press charges is determined by advice from the Special Crime and Counter Terrorism Division of the CPS. This can be a complex decision but they tend to follow the test for GNM set by House of Lords R v. Adomako.³ Lord Mackay said that the test should be whether Dr Adomako's conduct and breach of care was 'so bad in all the circumstances that he was placed' as to constitute a crime. In an attempt to clarify matters, the concept of recklessness has been introduced to define what may be considered 'gross negligence'. Recklessness is having an awareness of the consequences of an action, inaction or omission, but continuing regardless. Whilst this concept may be helpful, it remains for a jury to decide whether the events go beyond a matter of compensation for the victim and constitute a crime.

A BLUNT INSTRUMENT

Most of us would accept that health professionals should not be exempt from the criminal process. However, the criminal law can be a very blunt instrument when applied to such a complex field as healthcare. The legal process is also inevitably adversarial and seeks to find someone accountable when charges are brought. Grey areas of clinical judgement cannot always be reduced to a 'yes' or 'no' answer, it can be a 'maybe'. Over-simplification may misrepresent the multi-layered nature of any serious untoward medical incident. Most occur as 'the result of a chain of relatively small mistakes and the contribution of each individual is often either impossible to determine or so small that it cannot be said to be a substantial cause of death'.⁴

SYSTEMS FAILURES

Although one NHS trust has been charged with corporate manslaughter, most prosecutions for gross negligence have involved individuals. Hospital systems failures have not provided defence in many cases, even

when they may have been an important context to the adverse outcome. Although the individual is supposed to be judged in 'all the circumstances in which (s)he was placed', the prosecution hinges around the standard of care given by the individual charged and the precise significance of hospital systems may not always be evident, given the number of interactions involved. Such complexity leaves a lay jury very dependent on the statements of the expert witnesses, who are expected to give their informed opinion of the facts. It is well known that there can be considerable variation in the quality of their testimony, yet the jury must decide largely on the basis of their performance as they are necessarily members of the public without knowledge of healthcare in all its varying forms. Added to this is the possibility that organisations may wish to minimise their responsibility for a bad outcome, such that one or two individuals may find themselves facing many different legal parties and multiple jeopardy as a result of numerous investigations, all potentially discloseable to the criminal court.

Table 1 Summary of CPS charging decisions against healthcare professionals of manslaughter by gross negligence between December 2014 and December 2015 (based on information in the media) and an NHS trust.

| | Deceased | Accused | Profession | Negligent act alleged | Charged (or first court appearance) | Outcome |
|----|---------------------|---|-----------------|--|-------------------------------------|----------------------|
| 1 | Vincent Barker | Honey Rose | Optometrist | Missed papilloedema | 2015-09-08 | |
| 2 | Frances Cappucini | Dr Errol Cornish | Anaesthetist | Anaesthetic issues post Caesarean section | 2015-05-08 | |
| 3 | Frances Cappucini | Dr Nadeem Azeez | Anaesthetist | Anaesthetic issues post Caesarean section | (Arrest warrant issued) | |
| 4 | Jack Adcock (Mount) | Dr Bawa-Garba | ST6 paediatrics | Missed sepsis and DNAR confusion | 2014-12-17 | Convicted 2015-11-04 |
| 5 | Jack Adcock (Mount) | Theresa Thomas | Sister | Failure to supervise/intervene in a case of sepsis | 2014-12-17 | Acquitted 2015-11-04 |
| 6 | Jack Adcock (Mount) | Isabel Amaro | Staff nurse | Observational and escalation failure in a case of sepsis | 2014-12-17 | Convicted 2015-11-02 |
| 7 | Phoebe Willis | Carrie-Anne Nash | Nutrition nurse | Feeding tube peritonitis | 2015-09-18 | |
| 8 | Aisha Chithira | Dr Adedayo Adedeji | Doctor | Operative error during termination; haemorrhage | 2015-06-19 | |
| 9 | Aisha Chithira | Gemma Pullen | Nurse | Operative error during termination; haemorrhage | 2015-06-19 | |
| 10 | Aisha Chithira | Mgt Miller | Nurse | Operative error during termination; haemorrhage | 2015-06-19 | |
| 11 | Frances Cappucini | Maidstone and Tunbridge Wells NHS Trust | | Corporate manslaughter | 2015-05-22 (Preliminary hearing) | |

POSSIBLE RISK FACTORS

Those practising in higher-risk specialties such as surgery, anaesthesia, and obstetrics might be particularly vulnerable to criminal prosecution for manslaughter, but general practitioners and even optometrists are not without risk. Empirical analysis also shows that there are a disproportionate number of GNM prosecutions against non-white medical practitioners.⁵ The reasons behind this are likely to be complex. Colorectal surgery is particularly recognised as a subspecialty with a high risk of devastating complications, as the bowel is an unforgiving organ and the assessment of the acute abdomen can often be difficult. The discipline of laparoscopic surgery also demands additional skills and the margin for error is small. An increasing number of surgical patients are elderly and have multiple comorbidities, not least obesity, adding to the risks of serious complications. Patients now rightly have higher expectations. In our attempts to make medical practice understandable, doctors as well as the media may give the impression that medical decision-making is straightforward. In actual fact, surgery and medicine have become increasingly complex and arguably less predictable. Hindsight remains a wonderful thing.

DUTY OF CANDOUR AND DEFENSIVE MEDICINE

Is this upward trend of criminal investigation in healthcare a threat to transparency? A recent survey of 1400 UK doctors conducted via doctors.net.uk⁶ showed that nearly 90% of doctors polled admitted to being more defensive as a result of the fear of litigation, but less than half thought that they were delivering safer care as a result. 85% agreed or strongly agreed that being open about mistakes was less likely with increasing involvement of the law. This problem was recognised by Donald Berwick as part of the National Advisory Group on the Safety of Patients (NAGSPE)⁷ when it was concluded that fear is toxic to both safety and improvement and that blame should be abandoned as a tool. In this respect, the aviation industry is often cited as an example of good practice.

Transparency is the key to improving patient safety and reducing incidents of avoidable harm, yet it is hard to see how the recently introduced 'duty of candour' can be effective if it may lay the practitioner open to criminal charges. The consequential practice of 'defensive medicine' also implies increased costs and problems of staff recruitment, morale and retention, especially in specialties considered high risk. A new survey is currently underway to investigate this matter to which we invite replies by all frontline clinicians, especially surgeons.⁸

‘We are all only one error away from potential criminal prosecution’

HOW CAN MEDICAL PROFESSIONALS RESPOND TO THESE CHALLENGES?

Last year, a landmark conference in London on medical manslaughter and avoidable harm brought doctors and lawyers together outside the courtroom. It was significantly over-subscribed, with many citing their concerns following the highly publicised imprisonment for gross negligence manslaughter of senior colorectal surgeon David Sellu in November 2013, a conviction now granted a full appeal hearing this year. Following the conference, an open letter signed by over 300 senior doctors expressed serious concerns about the perceived increased involvement of the criminal process in healthcare.⁹ As a result, the Academy of Medical Royal Colleges has agreed to facilitate a meeting with the Coroners service, Ministry of Justice and other stakeholders to discuss how best to improve standards for expert witnesses. Their regulation was considered to be best

dealt with by the GMC.

As clinicians we should be justifiably concerned at the risks of facing criminal prosecution when adverse events occur. Our employers cannot be relied on to support us in such circumstances, so expert advice from medical defence organisations and specialist solicitors should be sought at the earliest opportunity. Those happy with the status quo are probably not the ones likely to be adversely affected by it. As a profession, we must continue to engage in robust debate with politicians, law makers, the royal colleges and healthcare management to ensure patient safety, transparency and best practice are not compromised by the threat of criminal prosecution. Any future review of the law on manslaughter and its practical application could be greatly assisted by such a debate.

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Jenny Vaughan is a consultant neurologist and co-founder of www.doctorsandmanslaughter.org.uk.