

Managing medical manslaughter cases: improving efficiency and transparency?



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Managing medical manslaughter cases: improving efficiency and transparency?

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Research Report submitted to the Crown Prosecution Service and the General Medical Council Independent Review of Gross Negligence Manslaughter and Culpable Homicide.

Introduction:

This research project has involved working in partnership with senior lawyers and policy officials at the Crown Prosecution Service to identify ways of improving the efficient and transparent management of ‘medical manslaughter’ cases. Although data is limited, there has been concern about an apparent increase of investigations and prosecutions over the past two decades which has generated considerable disquiet amongst health care professionals.¹ The test for gross negligence manslaughter has long been the subject of academic criticism for its vague, circular nature which relies heavily on the exercise of prosecutorial discretion.² Research has also identified discrepancies in how grossness is applied in practice³ and raised questions about the role of experts and expert evidence in this context.⁴ Whilst such cases remain relatively rare, the fact that there have been four manslaughter cases involving health care professionals reaching the Court of Appeal in the past three years reflects the continued uncertainty about key questions of criminal law and process.⁵ Indeed, the degree of concern felt by health care professionals saw the Secretary of State for Health establish a review into the application of Gross Negligence Manslaughter (GNM) in healthcare, chaired by Professor Sir Norman Williams.⁶ This rapid policy review published its report in June 2018 and has been followed by a more comprehensive review commissioned by the General Medical Council, chaired by Mr Leslie Hamilton, and which is due to report in June 2019.⁷

¹ R. Ferner and S. McDowell, Doctors charged with manslaughter in the course of medical practice, 1795-2005: a literature review. *J R Soc Med* 2006; 99: 309–14. M Brazier et al. Improving Healthcare through the Use of ‘Medical Manslaughter’? Facts, Fears and the Future. *Journal of Patient Safety and Risk Management* 2017; 22: 88–93.

² O. Quick, Prosecuting ‘Gross’ Medical Negligence: Manslaughter, Discretion, and the Crown Prosecution Service. *Journal of Law and Society* 33(3) 2006 421-50

³ D. Griffiths and A. Sanders, ‘The Road to the Dock: Prosecution Decision-Making in Medical Manslaughter Cases’ in D. Griffiths and A. Sanders (eds), *Bioethics Medicine and the Criminal Law*, Vol. 2, Medicine Crime and Society (CUP 2013) 117.

⁴ O. Quick, Expert Evidence and Medical Manslaughter: Vagueness in Action. *Journal of Law and Society* 38(4) 2011 496-518

⁵ *R v Sellu* [2016] EWCA Crim 1716, *R v Rudling* [2016] EWCA Crim 741, *R v Bawa-Garba* [2016] EWCA Crim 1841, *R v Rose* [2017] EWCA Crim 1168

⁶ <https://www.gov.uk/government/publications/williams-review-into-gross-negligence-manslaughter-in-healthcare>

⁷ <https://www.gmc-uk.org/about/how-we-work/corporate-strategy-plans-and-impact/supporting-a-profession-under-pressure/independent-review-of-medical-manslaughter-and-culpable-homicide>

Whilst the criminalisation of medical failure has always been a controversial subject, recent professional concern and policy attention has been unprecedented.⁸ Beyond concerns about the criminalisation of gross negligence, questions have been asked about the efficiency and transparency of the criminal justice system decision-making process in these cases. It can take years from the date of death before a decision is made over whether or not to prosecute, putting stress on all the parties involved, and significantly increasing financial costs. Agencies such as the police often have little experience of these cases and struggle with the process of gathering evidence and making confident decisions.⁹ They should refer all cases to the Special Crime Unit (SCU) which forms part of the Special Crime and Counter Terrorism Unit (SCCTD) within the Crown Prosecution Service (CPS) early on for assistance but previous research found that this is not always the case.¹⁰ The process of decision making is also relatively poorly understood, and the available legal and prosecutorial guidance is notable for its vagueness. Against this background, this project involved the researchers spending four weeks accessing CPS case files and working with staff at the Special Crime Unit in London and York in order to better understand the current practice for managing such cases and explore the merits of developing guidelines and policies which may enhance efficiency and transparency.

Scope of research and methodology:

The precise scope of the research, which was carried out in two phases between July and October 2018, was as follows:

1. Collecting data on the incidence of cases and the profession/speciality of defendants.
2. Measuring the length of time for cases to be disposed of, consider the sources of delay, and whether this may be reduced.
3. Understanding how expert witnesses are instructed and managed.
4. Exploring the merits of designing a specific prosecution policy, or more precise guidance on the offence of manslaughter by gross negligence.

Phase 1:

We synthesised existing data from CPS records relating to manslaughter cases involving healthcare professionals. At the beginning of this project we were provided with a table of 190 cases from CPS of all known investigations brought to their attention between 2007 and early 2018. The CPS informed us that this table was compiled manually, relied heavily on 'corporate memory' but that they were reasonably confident of its accuracy. We identified two omissions which we subsequently added to the table provided to us, giving a final number of 192. However, aside from those omissions, we have crossed checked the data with that

⁸ For example, the striking front cover of the British Medical Journal on 9th March 2019 (see R Ameratunga, Criminalisation of unintentional errors. *British Medical Journal* 2019; 364:l706)

⁹ Above note 3

¹⁰ Above note 3

cited in the Williams Review and data gathered in the Griffiths and Sanders¹¹ study and are satisfied of its accuracy. Ultimately, we are confident that this is likely to represent the most reliable data which exists on the number of cases which come to the attention of the CPS.

The table of 192 cases contained basic factual information about each case: suspect name, date of incident or referral, and the outcome. For some cases, but not all, the table also contained the suspect's medical speciality, a brief description of the failure in question, and the time taken for making decisions whether or not to prosecute. The table was then used in order to select a smaller sample of cases for qualitative analysis. These closed cases (i.e. they had completed their progress through the courts or the prosecutorial decision-making process) were then selected for closer analysis and were composed of the following categories:

- i) Prosecuted cases (P) – 9 cases
- ii) Early Investigative Advice given to police to end investigation (EIA) – 5 cases
- iii) Full Code Test applied leading to decisions not to prosecute (FCT) – 5 cases

This smaller sample represented 10% of the total number of cases on the table.

We performed quantitative analysis on the table of 192 cases. This included measuring the number of referrals over time and also the time taken for making prosecutorial decisions. Data in respect of the former has been notoriously difficult to ascertain, and data about the latter has not previously been collated or published. Data on time taken was only available in 44 cases out of the 192. Ideally, we would have had access to the data on all 192 cases, which would have undoubtedly strengthened the robustness of this part of the study.

We took a qualitative approach to the case file analysis of the smaller sample of 19 cases in order to gain an in-depth understanding of the decision-making process in these cases. The cases all involved registered doctors and nurses and covered an eleven year time-period between 2007 and 2018. Case files consisted of advice files (where early advice on how and if to proceed with an investigation had been given to the police on the basis of initial scoping investigations rather than full investigation) and full review files (where the CPS had conducted a full review of the evidence gathered from a detailed investigation and had either decided or advised on whether or not to proceed with a prosecution). We recognise that our analysis offers a selected and partial version of events: certain reports and correspondence may have been missing and our analysis is affected by our interpretive frameworks on them. However, the sample of 19 cases is a sufficient number to allow a valid analysis of the types of cases the CPS received during this period and permitted an in-depth exploration of prosecutorial decision-making, and consideration of ways of improving efficiency and transparency. We undertook a qualitative documentary content analysis of the case files. Using a coding frame, we grouped various features of the cases into categories for comparison.

¹¹ Above note 3

Phase 2:

The second phase involved conducting semi-structured interviews and focus groups with CPS casework lawyers. We spoke to 15 lawyers of varying experience and position based in the SCU. These interviews and focus groups sought to give a deeper understanding of the overall processes involved in decision-making as well as address questions and gaps from within the files. Detailed discussion of the data from this part of the study will be explored in separate publications. This report focuses on presenting data in relation to number of cases referred and prosecuted by the CPS between 2007-2018, and presents a series of recommendations for improving the efficient and transparent handling of such cases.

Research Funding:

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Danielle Griffiths was funded by the University of Sussex.

Research Ethics:

We applied for and obtained Government security vetting and also obtained approval from the CPS to conduct the research. The research was also approved by the Research Ethics Committee of the Faculty of Social Sciences and Law at the University of Bristol (ref 75981/2018)

1. ‘Medical Manslaughter’ - the evolution (and management) of a contested crime:

This section presents a short summary of the law of GNM before setting out the current arrangements by which such cases are handled in the Criminal Justice System.

Prosecutions of healthcare professionals for manslaughter following fatal mistakes are rare. The first known prosecution occurred in Newcastle in 1329 where a professional man was found to have killed his patient involuntarily and was ‘commended to God.’¹² Negligent homicide can be traced to the 16th Century and the gloss of “gross” emerged in the 19th Century where we find the first cluster of cases.¹³ Although such cases are unusual, their tendency to challenge the basis of liability has often led them to the appeal courts and into law reports as leading authorities on manslaughter.

In *R v. Adomako*¹⁴ an anaesthetist lost his appeal against conviction after fatally failing to spot a disconnected oxygen tube during a routine eye operation. Lord Mackay of Clashfern endorsed the ‘test’ for gross negligence:

“In my opinion the ordinary principles of the law of negligence apply to ascertain whether or not the defendant has been in breach of a duty of care towards the victim who has died. If such breach of duty is established the next question is whether that breach of duty caused the death of the victim. If so, the jury must go on to consider whether that breach of duty

¹² See A. Arlidge, ‘Criminal negligence in medical practice.’ (1998) (1) *Medico-Legal Journal* 3-14

¹³ J. Horder, Gross Negligence and Criminal Culpability. (1997) 47 *University of Toronto Law Journal* 495-521

¹⁴ [1994] 3 All ER 79

should be characterised as gross negligence and therefore as a crime. 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."¹⁵

Lord Mackay acknowledged that this 'involves an element of circularity' in that negligence will be gross and thus criminal if the jury thinks that it ought to be criminal.

This was endorsed by the Court of Appeal in *R v Misra, Srivastava*¹⁶ where GNM survived another attack on its compatibility with legal certainty. In dismissing the appeal of two junior hospital doctors who failed to diagnose and manage a patient with a post-operative infection, the Court of Appeal also considered that the law of GNM to be compliant with legal certainty:

"Vague laws which purport to create criminal liability are undesirable, and in extreme cases, where it occurs, their very vagueness may make it impossible to identify the conduct which is prohibited by a criminal sanction. If the court is forced to guess at the ingredients of a purported crime any conviction for it would be unsafe. That said, however, the requirement is for sufficient rather than absolute certainty... Moreover, there is a distinction to be drawn between undesirable, and in extreme cases, unacceptable uncertainty about the necessary ingredients of a criminal offence, and uncertainty in the process by which it is decided whether the required ingredients of the offence have been established in an individual case."

In 2017, the test for liability was clarified or modified (depending on one's analysis) by LJ Leveson's judgment in the case of *R v Rose*¹⁷ to the following five stage test:

- (a) duty of care
- (b) negligent breach
- (c) reasonably foreseeable that the breach gave rise to a serious and obvious risk of death
- (d) breach caused the death
- (e) circumstances of the breach were truly exceptionally bad and so reprehensible as to justify the conclusion that it amounted to GN and required criminal sanction

In terms of formal arrangements for handling such cases, the police are responsible for conducting investigations, although they are encouraged to involve the CPS Special Crime Unit (SCU), which is part of the SCCTD, at an early stage. Responsibility for decision making and communication to affected parties differs depending on the ultimate outcome in cases. For cases not prosecuted after EIA from the SCU, this is formally a decision of the police who are also responsible for communicating their decision to those affected. Cases which proceed to a FCT, but are nevertheless not prosecuted, are CPS decisions. Those aggrieved by decisions

¹⁵ Ibid at 86-7

¹⁶ [2004] EWCA Crim 2375, at paras 34-35

¹⁷ [2017] EWCA Crim 1168

not to prosecute may access a scheme called the Victim's Right to Review (VRR)¹⁸ and beyond that have recourse to judicial review proceedings.¹⁹ Similarly, decisions to prosecute are ones for the CPS. Cases are handled individually by specialist prosecutors within the SCU with supervision provided by the Head of Unit. Previous research has observed that this is a complex and dynamic process with many moving parts which may also involve drawing on the opinions of expert medical witnesses and specialist barristers commissioned to provide independent advice. Until 2019, we understand that only GNM cases involving health care professionals were routinely referred to the SCU, although this is now recommended for all GNM cases irrespective of the particular context for the death.

2. Data on the incidence of investigation and prosecution:

There has long been concern about an apparent increase of investigations and prosecutions of healthcare professionals for gross negligence manslaughter. Ferner and McDowell's search of newspaper and medical journal databases found a total of 177 health professionals charged with manslaughter between 1795-2005. Of these, 85 were doctors and over half (44) occurred between 1975-2005.²⁰ Quirk found a similar increase of reported prosecutions between 1867-1989 (7), 1990-1999 (17) and 1995-2005 (38).²¹

More recent evidence casts doubt on such increases and suggests that the number of doctors charged has been decreasing from 25 between 1995-2005 down to 15 between 2006-2015.²² In terms of empirical research, Griffiths and Sanders examined a sample of 75 CPS files of cases considered between 2004-2009 and found only 4 which resulted in prosecution.²³ Data on 'medical manslaughter' cases is not specifically recorded by the police or CPS, instead, such prosecutions fall within the bigger category of all cases of manslaughter. For this reason the sample of cases in Griffiths and Sanders' research was not reliable as the cases were only those which the CPS could locate at the time, however their qualitative analysis of prosecutorial decision making in the case files showed that there had been no lowering of thresholds within the CPS in order to pursue such cases (as some authors had speculated).

Data provided by the CPS to the Williams Review estimated that the CPS receive about 200 referrals a year nationally for all categories of manslaughter by gross negligence.²⁴ In terms of those involving health care professionals, there have been 151 cases referred to the CPS between January 2013 and March 2018. Based on a longer time period between 1995-2018, the deaths of 38 patients have led to gross negligence manslaughter prosecutions of 47 healthcare professionals (37 doctors, nine nurses and one optometrist). Twenty three of these healthcare professionals were convicted, with four prosecutions subsequently

¹⁸ <https://www.cps.gov.uk/legal-guidance/victims-right-review-scheme>

¹⁹ For example, see *DPP v Rowley* [2003] EWHC 693

²⁰ Above note 1

²¹ H. Quirk, 'Sentencing White Coat Crime: The Need for Guidance in Medical Manslaughter Cases.' *Criminal Law Review* [2013] 11 871-888

²² P. White, 'More doctors charged with manslaughter are being convicted, shows analysis.' *British Medical Journal* 2015;351:h4402

²³ Above note 3

²⁴ Above note 6 at page12

overturned on appeal.²⁵ All of these studies acknowledge limitations in terms of the reliability of newspaper reporting or representative sampling yet, whether there has been an increase or not, they all show there has been a small and stable number of prosecutions. Despite this there have been enough cases to create a perception of over prosecution among healthcare professionals. Gathering more reliable data was a central aim of this study in order to better understand whether such fears are well founded or not.

It is not just prosecutions which are of concern. Griffiths and Sanders' (2013) research which included data from coroners, found that the number of police investigations, in particular those which do not get to SCU, increased significantly between 1999 and 2009. This was due to the fact that families, coroners and police are for various reasons now more likely to refer medical cases for criminal investigation.²⁶ The exact number of police investigations where referral to the CPS was not deemed necessary is unknown though likely to be a bigger number than the number of cases where the CPS are involved. Thus *if* there has been any increase in prosecutions, it is likely to be partly related to the increased prospects of a case being referred to the police in the first place. While we know police are now more likely to refer these cases to SCU much earlier than they did 10 years ago, the exact figures on number of police investigations which do not reach SCU (where perhaps the police have decided it is clear there is no case to proceed with) is unknown and beyond the scope of this research.

An important question involves how cases enter the Criminal Justice System? Although beyond the remit of this project, better understanding of how tragic incidents evolve into investigations is needed, particularly because it is likely that the perceptions of over prosecution may stem from the incidence of healthcare professionals being reported to the police when the incident will clearly not reach the threshold for a criminal prosecution. Research by Griffiths and Sanders²⁷ identified the following key factors that appear to influence which cases end up as criminal investigations:

- Character of victims (age and vulnerability)
- Character of defendants
- Coronial judgment and referral
- Active family
- Publicity
- Interviews of suspects
- Liaison between the police and CPS
- The role of the CPS SCU

²⁵ *ibid*

²⁶ Above note 3

²⁷ Above note 3

A central aim of this study was to try and access more reliable data on the number of prosecutions and investigations that do reach CPS SCU. It is important to be clear on what is meant by investigations here, as the term is often used generically to encompass investigations by a range of different actors such as employers, coroners, regulators, and also by the police and CPS, which will all be different in terms of their scope and nature. Strictly speaking, the CPS does not conduct investigations. In this project, investigations refers to all known cases which have been referred by the police to the SCU for advice.

The table provided to us by the CPS, along with the extra cases we identified, amounted to a total number of 192 cases, many involving more than 1 suspect. The total number of suspects (both individual and organisational) is 269, made up of 219 individuals and 50 organisations. The higher number of investigations here compared to those cited in the Williams Review is explained by the longer time period for our table (2007-2018 compared to 2013-2018). In terms of individuals, the profession of the suspect is not always listed, but it is dominated by doctors, nurses, pharmacists, in that order. We do not have data on the age, gender or ethnicity of the suspects in these cases.

In terms of outcome, these cases fall into three main categories:

- (i) Prosecuted (P)
- (ii) Not prosecuted based on Early Investigative Advice (EIA), and
- (iii) Not Prosecuted based on Full Code Test (FCT).

The breakdown of the table of 192 cases is as follows:

12 prosecutions (including two guilty pleas)

178 non prosecuted cases, broken down in detail as follows:

100 not prosecuted based on EIA

60 not prosecuted based on the FCT

15 cases still under review (SUR)

1 charges dropped

1 unknown

1 unaccounted for.

Figure 1: CPS case referrals for medical manslaughter between 2007-2018

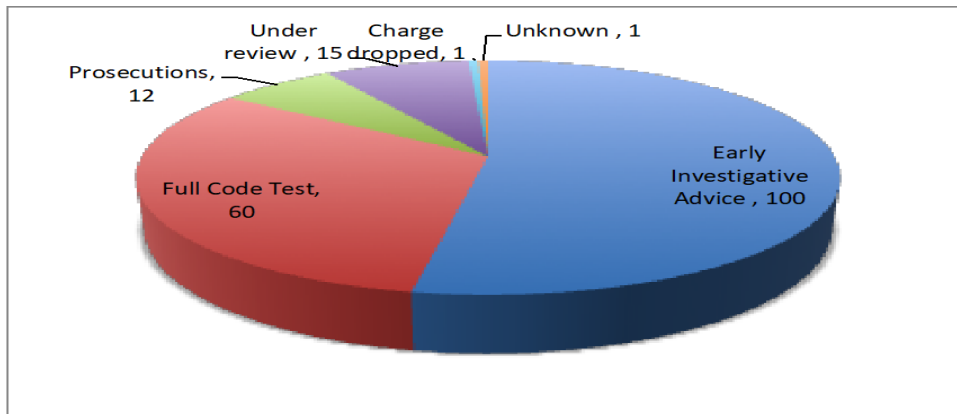


Figure 2: CPS case referrals for medical manslaughter between 2007-2018 (percentages)

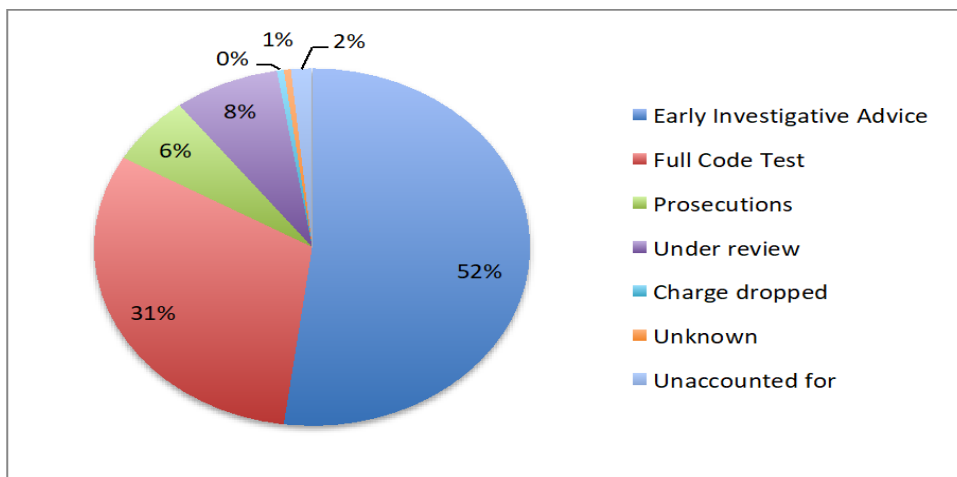


Figure 2 shows that EIA make up the majority of cases (52%). Prosecutions make up only 6% and may actually be less when accounting for those which are ‘unknown’, ‘unaccounted for’, and should no prosecutions emerge from those currently being examined (under review). Of the EIA and FCT case files we looked at, there was no evidence to suggest that the case had been referred needlessly e.g. it was/should have been clear from the start, even to a coroner or police officer with little experience of these cases, that the case was not a potential criminal offence. However, this was a small sample of the overall number of cases referred to the CPS, and further examination of a larger sample of cases is needed in order to understand whether there are any clear unmeritorious referrals.

Figure 3: Prosecutions by Profession (2007-2018)

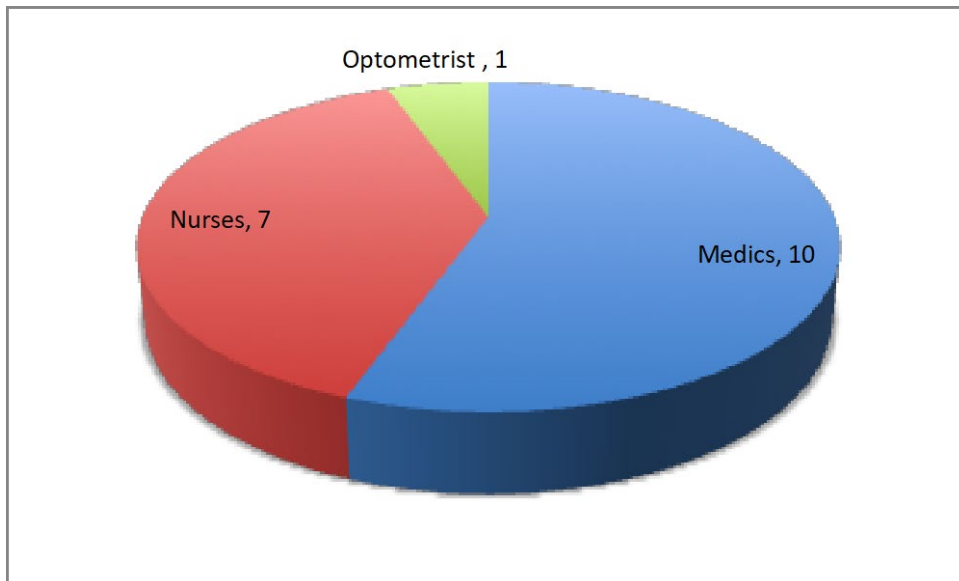


Figure 3 shows that of the 12 cases prosecuted since 2007, the majority involved medical professionals. In this study we have not analysed the type of failures in these 12 cases, or any other variables in order to discover why medics were more likely to be prosecuted, but this will be a focus for subsequent analysis.

Figure 4: Number of referrals between 2007 and early 2018

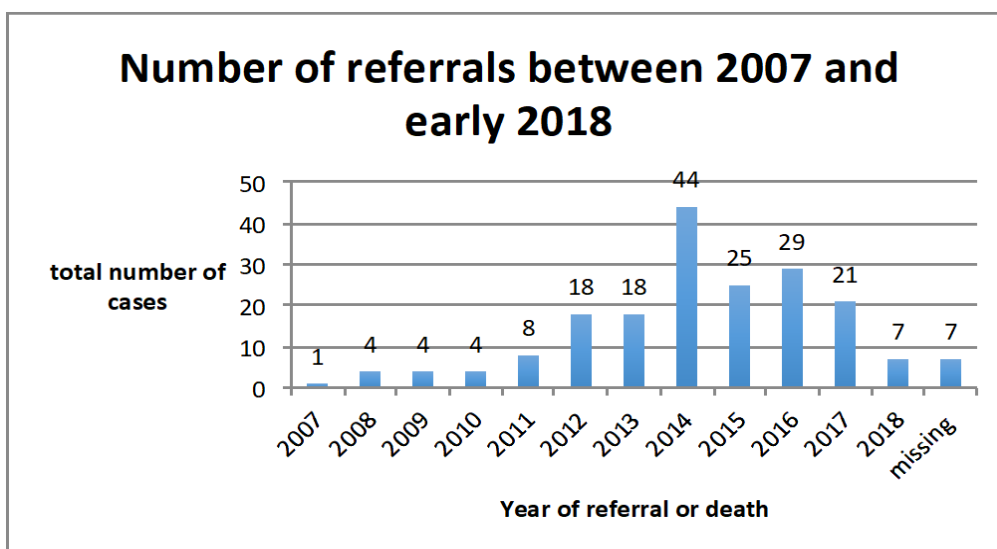


Figure 5: Number of referrals by year and type of case (2007-2018)

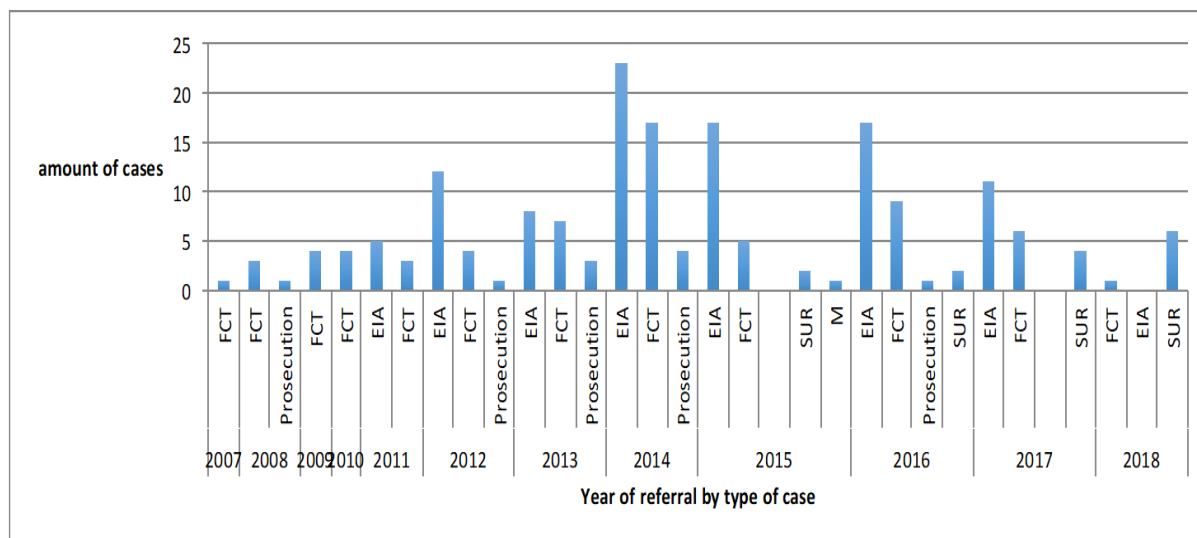


Figure 4 and 5 shows the timeline of referrals to SCU between 2007 and early 2018. The figures show that there has been a rise in referrals especially between 2011 and 2017, with 2014 having a particularly high number. There were relatively few referrals before 2011 but this could be due to the fact that corporate memory is stronger in more recent years. However, the data does show that while there has been a spike between 2014-2015, the figures year on year seem to be decreasing since 2017 and were stable before 2011. In addition, any concerns among healthcare professionals about the spike and the increases since 2011 need to be treated with caution. Awareness of the need for referral has risen in the past 5 years or so and such awareness could correspond with the trends identified in Figure 4. Even if the data shows that healthcare professionals are more likely to face investigation, as stated earlier, this is likely to be due to increased awareness of potentially blame worthy medical failure among families, coroners and the police. It may also be reassuring that, as we stated earlier, none of the referrals we looked at appeared to us as 'weak' cases which did not warrant even early investigative advice, although our sample of cases was small.

More concerning may be if these referrals are translating into more prosecutions which we discuss next.

Figure 6: Prosecution by year referred (2007-2018)

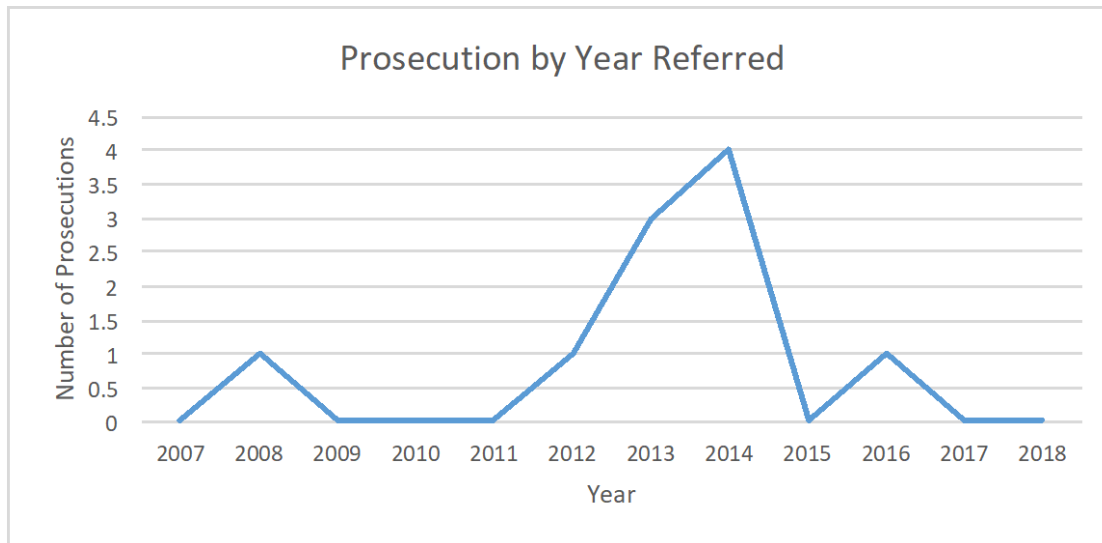


Figure 6 shows prosecutions by the year the case was referred (based on 10 of the 12 prosecutions as data on date of referral was missing for two prosecutions), as opposed to the year the case was prosecuted. There was a spike in 2014 in cases that went on to be prosecuted which corresponds to the spike in referrals for all types of cases in that year (Figures 4 and 5). Again, explanations for the spike in 2014 is unknown – this could merely be an anomaly or it could be that high profile cases around this time led numerous agencies to refer cases more frequently in that year. What is significant however is the fact that what looks like a rise in prosecutions reflects the a rise in the total amount of cases referred and thus the likelihood more will lead to prosecution is increased in that year only. Since 2014, rates of prosecutions have declined significantly and remained low even though rates of referrals in 2015 and 2016 were still quite high. Therefore, it is unlikely the spike is due any increased propensity to charge healthcare professionals with this offence.

3. Timely decision making?

Given the vagueness of the legal test for GNM, the complexity of these cases and the reality that potential homicide cases will legitimately warrant some form of investigation, such cases are not amenable to speedy resolution. Such delay is costly - not only in terms of resources, but also the prolonged uncertainty and anxiety for grieving families and individual(s) under suspicion. In particular, it must be extremely difficult for a practitioner to continue working through the stress of a homicide investigation with the serious consequences and shame associated with this.

Data on the length of time taken from the date of death, to the date of referral and finally to the date of CPS decision has not previously been collated, let alone published. Ideally, we would have the relevant dates for all 190 cases in the table, but this was not possible within the confines of this study. However, we have been able to access the relevant dates for the

sample of 44 cases which we examined more closely. This is a limited sample size (23%) and nearly a quarter of these are prosecution cases which will take more time than other cases, so considerable caution is required in relying too heavily on this data. Nevertheless, the CPS has indicated that these timescales are broadly in keeping with their experience of handling these cases, thus providing us with some confidence about their likely accuracy. It also enables a comparison of time taken in the two Special Crime Units operating in London and York. It should be noted that the London data involves more prosecuted cases than York, which naturally take more time and which will affect the average time taken. In terms of data bearing on the efficiency of the decision-making process in such cases, the most relevant time scale is from the date of referral to the CPS to date of decision by the CPS. The reason for this is that there is sometimes a considerable gap between the date of death and the date of referral, and so the key timescale is from date of referral to date of decision. It should be noted that formal notification of the decision is a matter for the police, and we do not have the data for the dates when police make such communication to families of the deceased.

Figures 7, 8, 9, 10, 11 and 12 all relate to the amount of time taken from the date of referral to the date of decision in the 19 cases we selected for qualitative analysis. Figure 8 shows that EIAs take the shortest amount of time, an average of 5 months, FCTs take on average 11 months and prosecutions take on average 16 months. Figures 9, 10 and 11 show the differences in time taken for a decision between York and London. London takes on average 6 months longer, however out of the 19 cases we looked at London had a greater proportion of FCTs and prosecutions which take longer and thus is likely to be a significant factor in explaining this difference.

Figure 7: Length of time taken from date of referral to CPS to date of CPS decision

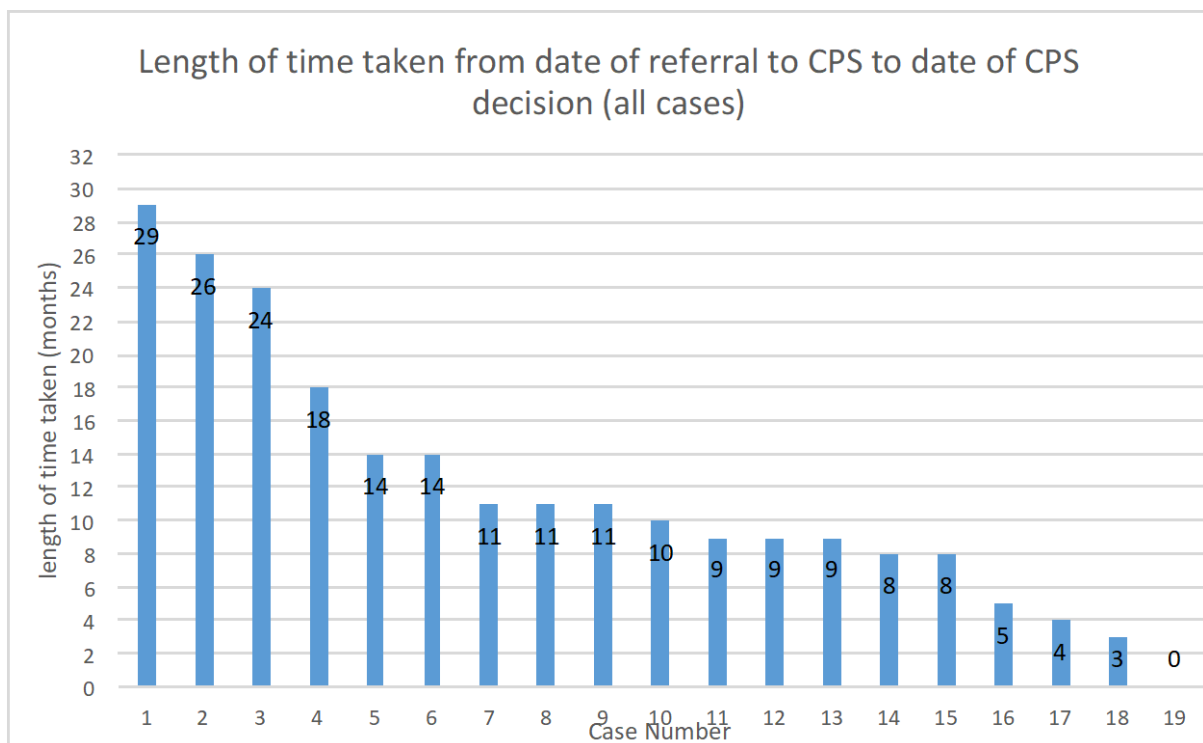


Figure 8: Average amount of months taken by type of case

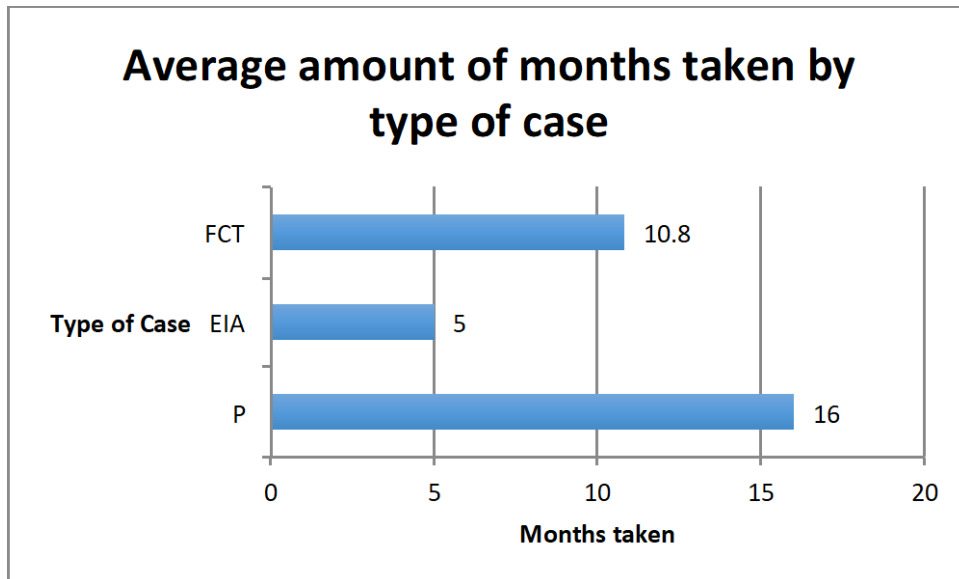


Figure 9: Length of time taken from date of referral to date of CPS decision York

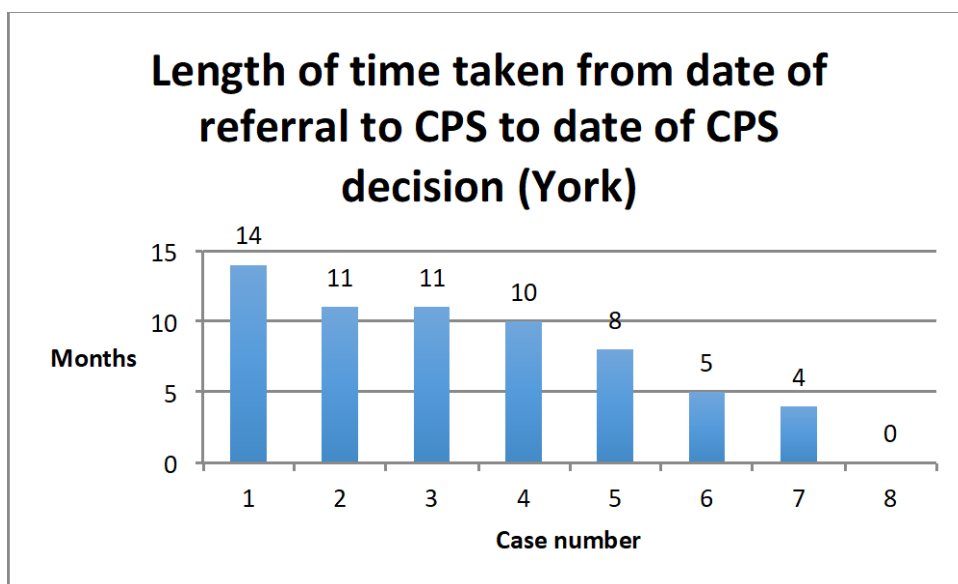


Figure 10: Length of time taken from date of referral to date of CPS decision (London)

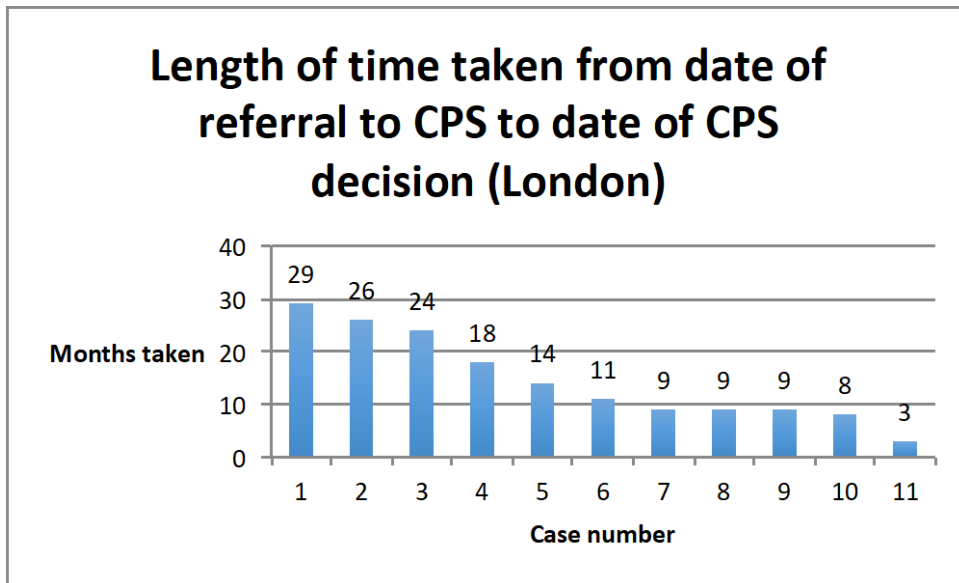


Figure 11: Average time taken from date of referral to date of CPS decision York and London

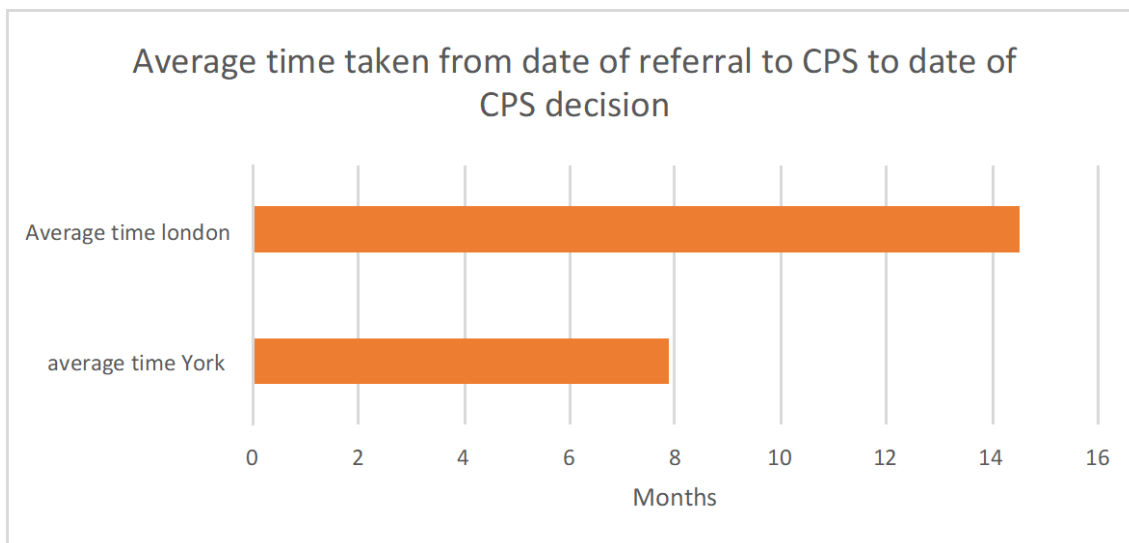


Figure 12: Average time taken from date of referral to date of CPS decision by case type

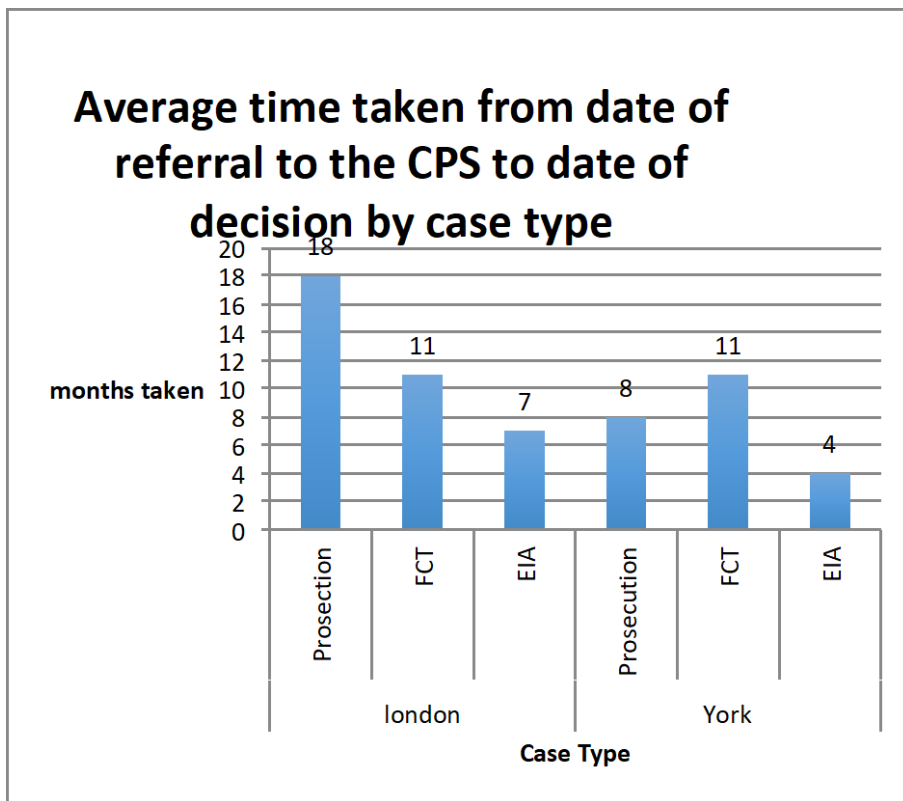


Figure 12 breaks down the time taken by type of case with York and London compared. London takes 10 months more in prosecution cases but this figure is skewed by the fact that York only had 2 prosecutions out of the 9 we looked at. The data for FCTs and EIAs are similar for York and London, with London taking slightly longer for EIA cases.

Figure 13: Length of time taken from date of referral to date of CPS decision in FCTs (44 cases)

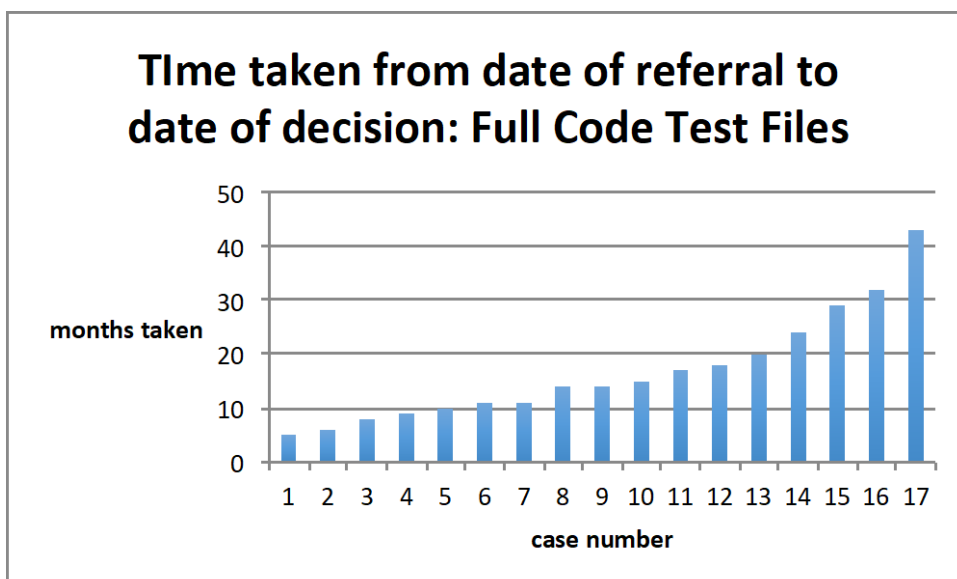


Figure 14: Length of time taken from date of referral to date of CPS decision EIAs (44 cases)

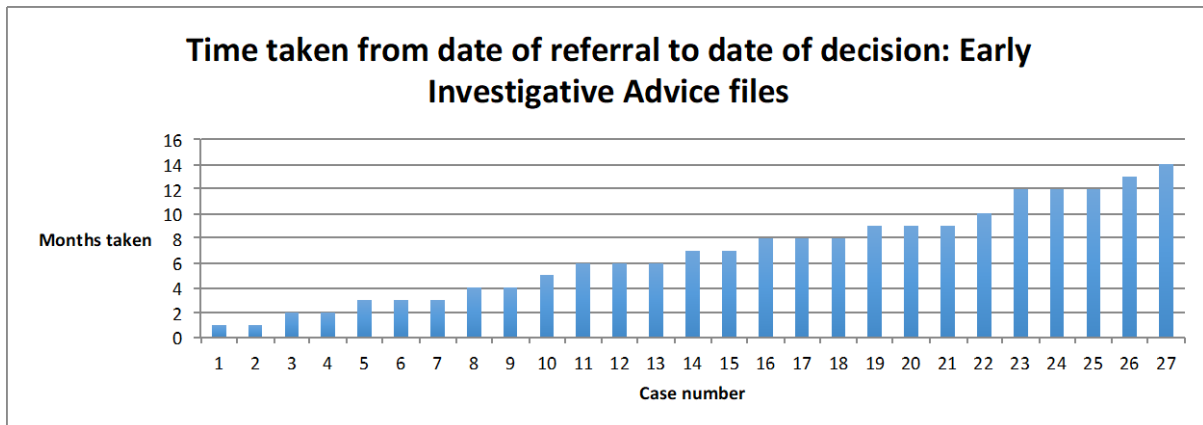
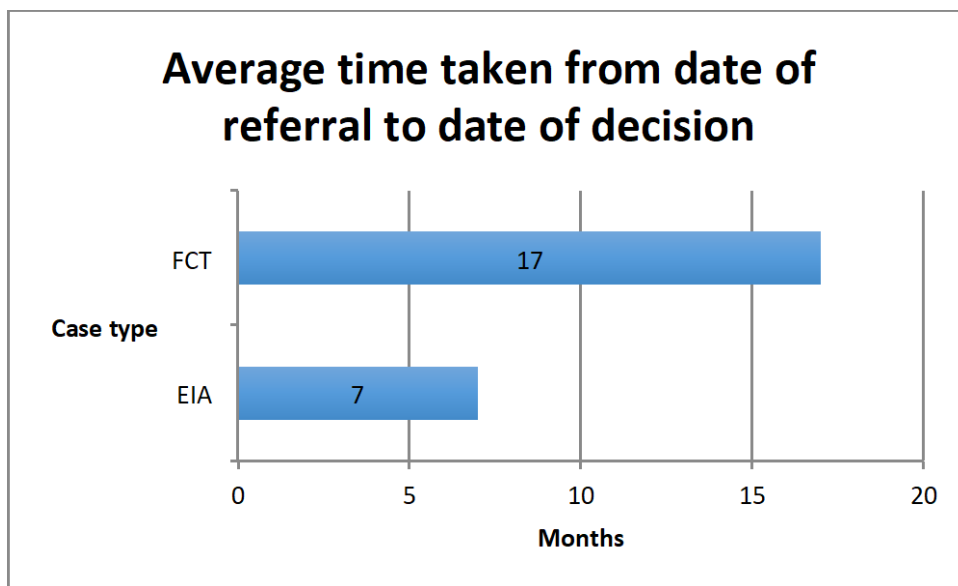


Figure 15: Average length of time taken from date of referral to date of CPS decision (44 cases)



Figures 13, 14 and 15 include data on time take from date of referral to date of decision in the 19 cases we selected as well as 25 cases from the table where information of these dates were given. In comparison to Figure 8 which showed 10 months for FCTs and 5 for EIAs, analysis of these additional cases in Figure 15 shows the average length of time may be a lot longer. The averages are however skewed by a couple of FCT cases which took over 30 months. Whilst most of the other cases took much less time than this they nevertheless still took a number of months in order for decisions to be made.

Discussion:

The data presented above confirms that making informed decisions in medical manslaughter cases can take a long time. Whilst all those concerned with such cases would prefer them to be dealt with more efficiently, there are a number of reasons which explain why this is difficult in this context:

- **Late referral.** A common theme in the interviews Griffiths and Sanders (2013) conducted over 5 years ago was that there were still many cases which were being referred to SCU late on or not at all. This often caused delay and inadequate or needless investigations. The current study's interview data and analysis of the cases shows that this late referral has decreased over the past 5 years. We did not see late referral in any of the 19 case files we looked at, although we do not know about cases which are not referred to the SCU.
- **Complexity of medical manslaughter cases.** The Code for Crown Prosecutors makes reference to making decisions in a 'reasonable period of time' which naturally depends on the relative complexity of investigations into different crimes in different contexts.²⁸ Medical manslaughter cases involve numerous complexities which result in the time taken for making decisions. The main complexities involve the delivery of healthcare, understanding patient safety failures, the identification of possible multiple suspects (including organisations), gathering evidence on gross negligence, gathering evidence on causation, managing the volume of evidence.
- **Police unfamiliarity.** As stated above, investigating healthcare professionals and organisations for possible manslaughter is far from routine police work, and this unfamiliarity leads to delay.
- **Police resources.** Due to decreasing police funding these cases seriously stretch already constrained resources. Whilst this project did not involve police and we have no evidence for the impact of such resourcing issues, it is clear that this will have some effect on the ability to conduct timely investigations.
- **Police prioritisation.** In the 2013 Griffiths and Sanders project²⁹ interviews with the police found that these cases can be a low priority in relation to other homicide cases particularly suspected murder cases.
- **Availability of appropriate experts.** A consistent theme in our interviews was that finding appropriate experts is difficult and was a further source of delay in dealing with these cases.
- **Communication with experts and counsel.** There can be a lengthy process of communication between experts and counsel. This communication can be slowed down when experts do not have appropriate training or there is misunderstanding interpreting letters of instruction.

²⁸ <https://www.cps.gov.uk/publication/code-crown-prosecutors>

²⁹ Above note 3

- **Care and professionalism.** The analysis of the case files and interviews revealed how much care CPS lawyers take in dealing with these cases and the need to not rush and ensure things were done as accurately as possible. There was a recognition of how sensitive the cases were in terms of both the victims and families, and the healthcare professionals involved.
- **Applying a vague legal standard.** There was also a recognition of the complexity of the law in this area which permeates decision making at all of the levels outlined above (police, prosecutors and experts.)

Many of the above factors which cause delay in medical manslaughter cases seem to be inherent to the cases themselves with no easy solution. Healthcare cases will always be complex and sensitive and thus take longer to deal with. The vague legal standard is also not something which is likely to change. Other factors, however, could be improved including how experts are instructed and ensuring the police are better equipped to deal with these cases when they arise. Such improvements are discussed in section 6.

4. Instructing experts:

Expert witnesses and expert evidence are of crucial importance to medical manslaughter cases. They are influential in two main ways: first, by informing prosecutorial decision making and secondly by assisting jury decision making for the few cases which proceed to trial. Constructing a case of gross negligence manslaughter is heavily reliant on expert evidence which has a major impact on the outcome of cases. Experts may be asked to assist in relation to answering the key questions at the heart liability for GNM (as set out in the leading cases summarised in section 1.) In the main, this boils down to giving opinion in relation to two key questions about: (i) the grossness of the conduct (was it truly exceptionally bad?) and (ii) its causative quality (did it make a significant contribution to the victim's death?).

Expert opinion evidence is admissible as constituting 'information which is likely to be outside the experience and knowledge of a judge or jury' as per the case of *R v Turner*.³⁰ The remit of an expert is to "furnish the judge with the necessary scientific criteria for testing the accuracy of their conclusions, so as to enable the judge or jury to form their own independent judgment by the application of these criteria to the facts proved in evidence."³¹ The leading authorities³² on the admissibility of expert evidence set out the following key questions: (i) will the proposed expert evidence assist the court? (ii) Does the witness have the necessary knowledge and expertise? (iii) Is the witness impartial in their presentation and assessment of the evidence? And (iv) Is there a reliable body of knowledge and experience to underpin the expert's evidence?

Ultimately, experts must assist the court in its overriding objective of giving unbiased opinions within their area of expertise, as per The Criminal Procedure Rules, Part 19.³³ Experts must also comply with principles set out by their professional regulators, for example the General

³⁰ [1975] QB 834, 841

³¹ *Davie v Edinburgh Magistrates* [1953] SC 34, 40

³² *Kennedy v Cordia* [2016] UKSC 6; *R v Bonython* (1984) 38 SASR 45

³³ <https://www.justice.gov.uk/courts/procedure-rules/criminal/docs/2015/crim-proc-rules-2015-part-19.pdf>

Medical Council's Good Medical Practice,³⁴ and its more specific guidance on Acting as a Witness in Legal Proceedings.³⁵ More generally, debate about the proper role of experts within the Criminal Justice System, especially within criminal trials, has revolved around the tension between juror education and juror deference, that is, whether experts are teaching juries about complex matters beyond their own comprehension, or effectively telling them how to decide the offender's guilt.³⁶ Ultimately, experts feed into the task of good criminal justice decision making, in particular, helping to distinguish between the innocent and guilty and between degrees of culpability.³⁷ The importance of expert evidence in medical manslaughter cases has been observed in previous empirical studies.³⁸ Whilst there is no legal rule requiring the use of such evidence in these cases, in practice prosecutors do not proceed without clear expert evidence which supports the prosecution's case of gross negligence. At the investigation stage, an expert opinion that the conduct does not amount to gross negligence will effectively end that investigation. The following quote from Quick's 2006 study³⁹ neatly summarises this:

'even if I think it's grossly negligent, if I've got an expert who says no it isn't I wouldn't be able to prosecute the case...[it] would be doomed to failure.'

The following key questions arise in relation to experts and their evidence:

- What is expertise?
- Who are experts?
- How are they selected?
- When is expert evidence needed?
- How reliable is expert evidence?
- What is it that experts think they are being asked to do?
- What do experts actually do in practice?
- How is expert evidence managed and regulated within the Criminal Justice System?

Whilst there are numerous questions about expert evidence, the focus within this study was on the relationship between prosecutors and experts, and more specifically to understand how prosecutors select and instruct experts by drafting terms of reference. In terms of the current position, there are no fixed rules on whether and when prosecutors instruct experts. However, for cases which appear prosecutable, prosecutors will routinely instruct experts to give opinions which will inform the assessment in relation to the breach and causation elements of liability. Experts may offer opinions in relation to both questions or separate experts may be instructed. As per the norm in such legal proceedings, there is no requirement for a minimum number of experts, or a second opinion system.

³⁴ <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice>

³⁵ <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/acting-as-a-witness>

³⁶ P. Roberts and A. Zuckerman, *Criminal Evidence* (OUP, 2010), 473

³⁷ M. Redmayne, *Expert Evidence and Criminal Justice* (OUP, 2001), 3

³⁸ Above note 4

³⁹ Above note 2 at 446

Whilst we did not view any sample letters of instruction to experts, we did discuss the drafting of such letters with individual prosecutors. These responses so suggest that there is some degree of variation in the form of wording used in such letters of expert instruction. This is in line with the general observation that prosecutors appear to enjoy individual discretion into the way that they manage cases. Naturally, such letters will vary in terms of the different facts and evidence available in each case. However, it also appears that prosecutors adopt different ways of setting out the law to experts. Some used their preferred summary from a range of case authorities (mainly *R v Adomako*, *R v Misra* and *R v Rose*), whilst some preferred not to cite cases at all.

The following quotes illustrate the room for individual discretion in the drafting of expert terms of reference:

“We all have our own templates for letters of instructions, which will all be slightly different...”

“I doubt it’s standardised...I don’t know, because I haven’t seen what others terms of refs docs looked like...so I adopted someone else’s, tweaked it my way...steering the experts owe get clear report”

“My practice, the law part remains unchanged, well it’s updated. HR sets out law with clarity...the law is the law. Approved by CA as the *Misra* direction, but you are right in terms of consistency across the board. Do other lawyers do that, I don’t know. I think it’s clarified the law...easier to understand...Consistency is everything, so yes, I agree with that. I’d be in favour of consistent front end for terms of instruction...”

This raises the question of whether greater standardisation is desirable in terms of the drafting of such letters. We think there is a case for ensuring a greater degree of consistency in aspects of the drafting of such letters. An agreed description of the law should be used in all such letters to ensure that all experts are working from the same rules. To be clear, the use of various descriptions of GNM from the leading authorities is perfectly valid and in no way illegitimate. But there is merit in mandating a consistent usage here to minimise the risk of different interpretations by experts.

5. The merits of a specific prosecution guidance for GNM?

This project also explored the views of prosecutors about the desirability of creating a specific prosecution guidance for making decisions in cases of GNM. To summarise, prosecutorial decisions are currently made with reference to the Code for Crown Prosecutors, issued by the Director of Public Prosecutions (DPP) under Section 10 of the Prosecution of Offences Act, and currently in its 8th edition. The code contains a two-stage test: (i) the evidential test (is there enough evidence for a realistic prospect of conviction?) and (ii) the public interest test. If there is sufficient evidence, prosecutions will generally proceed unless the prosecutor is sure that the public interest factors tending against prosecution outweigh those tending in favour. Paragraph 3.1 of the Code sets out the general position in terms of making decisions in serious or complex cases such as manslaughter by gross negligence:

In more serious or complex cases, prosecutors decide whether a person should be charged with a criminal offence and, if so, what that offence should be. Prosecutors may also advise

on or authorise out-of-court disposals as an alternative to prosecution. They make their decisions in accordance with this Code, the DPP's Guidance on Charging and any relevant legal guidance or policy. The police apply the same principles in deciding whether to start criminal proceedings against a person in those cases for which they are responsible.

The vagueness of GNM has long attracted academic criticism and has also been a source of anxiety for concerned clinicians following recent prosecutions of health care professionals. This raises a fundamental question of how broadly or narrowly criminal offences (or for that matter, other legal rules) should be drafted. The circularity of the test for assessing grossness was acknowledged by Lord Mackay in his judgment in *Adomako*. However, he also warned that 'an attempt to specify that degree [of grossness] more closely is I think likely to achieve only a spurious precision'.⁴⁰ Judges have, on the whole, heeded this advice and instead chosen to describe gross negligence with reference to a variety of synonyms. The two which appear to have gained the most traction are 'reprehensible conduct' (*R v Misra*) and 'truly exceptionally bad.' (*R v Sellu*, *R v Rudling*, *R v Rose*).

The refusal of the common law to be drawn into greater specificity has, somewhat predictably, placed pressure on the CPS to provide the missing detail from the leading authorities. In particular, there have been calls from those who feel at risk of prosecution for this offence for greater transparency in terms of the identification and publication of factors for or against prosecution. Of course, such a suggestion is contentious as this places prosecutors in an uncomfortable (indeed potentially unconstitutional) position of effectively becoming law maker.⁴¹ It clearly isn't the role of the CPS to provide such guidance, albeit that the trend for deferring legal details to prosecutors has been observed in academic scholarship.⁴²

In terms of more specific legal guidance or policy, up until 14 March 2019, the CPS Legal Guidance on this offence was succinctly stated as follows:

"The Grossness of the Breach: It is for the jury to decide whether the defendant's conduct was so bad, in all the circumstances, as to amount to a criminal act or omission. In *R v Misra and Srivastava* [2005] 1 Cr App R 328, the court agreed with the direction by the judge that the term 'reprehensible' would be apt to describe the nature of the conduct."

In our interviews and focus group discussions, we wanted to understand the views of prosecutors on whether more detailed guidance might assist their decision making. There was a consistent lack of support for the idea that such guidance would help, as reflected in the following comments:

"I'm not sure in GNM if it would be that helpful...having a better stated position on GNM would be helpful to everyone...but it would be unhelpful to have examples of cases, to pigeon-hole cases would be problematic..."

⁴⁰ *R v Adomako* [1995] 1 AC 171, at 187

⁴¹ For example, the 1688 Bill of Rights prevents the Crown or its servants from altering laws without the consent of parliament.

⁴² See A. Mullock, 'Prosecutors making (bad) law?' *Medical Law Review*, Volume 17, Issue 2, Summer 2009, Pages 290–299, and more generally D. Husak, *Overcriminalization: The Limits of the Criminal Law* (2008)

“It wouldn’t be helpful...it will regurgitate legal principles...if it went beyond that you are risking constitutional tension...the direction of travel is to provide more guidance to clarify legal concepts that have been left deliberately vague for juries to make decisions...real dangers in doing that...I’d be uncomfortable with that...”

“The factual circumstances are far too varied to come up with meaningful guidance...the parallel often brought up is Assisted Suicide...they key difference there is that the factual circumstances are nowhere near as varied as for GNM cases...much of that document is also about Public Interest factors...that’s a much easier process, and even that process was difficult...”

“If the only thing a policy doc achieves is re-states the law, are you really helping prosecutors...I struggle to see how this would be of meaningful assistance...it would be so general to be of no value...”

“When dealing with these cases I don’t have a checklist...the only one is the Adomako one...if I was writing a policy document I’d struggle to write anything beyond what is said in the authorities...”

However, the call for further prosecutorial guidance has been heeded in other contexts, most notably for the offence of Encouraging or Assisting Suicide⁴³ and for Dangerous driving. Prosecutors were wary about comparisons to these areas, mainly because Assisted Suicide largely revolves around the consideration of public interest factors, and the former involves a less complex and less varied set of circumstances. However, as noted below, we think that more detailed guidance would be beneficial in the context of medical manslaughter cases.

6. Recommendations:

Based on our analysis of the data and drawing on our previous research in this area, we make the following four recommendations.

(i) Improve police training

Given that this research did not involve the participation of the police it might seem inappropriate to make any recommendations which concern their involvement in such cases. However, we were able to explore with prosecutors their working arrangements with the police and obtain their observations in some detail at interview and focus groups. To be clear, the basic division of responsibility for dealing with the bulk of suspected crime is that the police investigate and the CPS make decisions whether or not to prosecute. However, in the context of ‘special crimes’ such as GNM, there is a significant blurring of this distinction in that prosecutors are generally involved in help focus the investigation, for example by requesting forms of evidence and drafting terms of reference for expert witness reports.

We note that the recommendation in the Williams Review for establishing a national specialist police unit was not welcomed by the police. We suggest that a more appropriate alternative is the creation of regional leads within the police who could be trained by specialist

⁴³ <https://www.cps.gov.uk/legal-guidance/suicide-policy-prosecutors-respect-cases-encouraging-or-assisting-suicide>

prosecutors from the SCU. This appears more realistic and represents an efficient way of the expertise from the SCU filtering down regionally.

(ii) Consistent usage of the description of GNM.

This echoes the similar call made in the Williams Review. There are clearly numerous terms from the case law which describe gross negligence, but there is merit in a consistent usage of ‘truly exceptionally bad.’ Whilst there are currently numerous alternate descriptions of gross negligence from the leading authorities, and all therefore valid, we do have concerns about possible different interpretations of these, especially by experts commissioned to give their opinions in light of such descriptions of the law. It would be preferable if the same description of GNM was used by all those involved in providing evidence or making decisions in such cases.

(iii) Standardising parts of expert instruction letters.

Whilst letters of instruction will always need to be tailored to the unique facts and circumstances of every case, we think there is a strong case for consistent usage of the agreed description of GNM within the front end of letters of instruction. This will hopefully reduce the risk of expert misinterpretation and also have the benefit of the making the process appear more consistent.

(iv) Designing more specific offence guidance.

Overall, we feel that more detailed guidance is desirable, both in terms of possibly assisting consistent decision making and also in terms of transparency. However, we feel that further research is needed here in order to test whether this would be helpful or not to Specialist Prosecutors, and indeed other such as the police, experts and coroners.

We note that on the 14th March 2019 the CPS published more detailed legal guidance on the elements of manslaughter by gross negligence.⁴⁴ This explains the process for handling such cases (by the Special Crime Unit) and gathers key passages from the leading authorities on this offence category. Whilst this is, in the main, a summary of existing statements of the common law, and thus unimpeachable, it does go slightly further in identifying ‘relevant factors in establishing grossness’ such as:

- A course of conduct and a series of breaches
- Deliberate ignoring evidenced based safety systems
- Ignoring warnings from colleagues

Again, we hope that further analysis of the data on the files we have accessed, and the possibility of looking closely at a larger number of cases will possibly allow the identification of other factors which might be associated (or not) with an assessment of gross negligence.

⁴⁴ <https://www.cps.gov.uk/legal-guidance/gross-negligence-manslaughter>

Conclusion:

This report contains the most accurate data published to date in relation to the number of GNM investigations and prosecutions in the healthcare context. Our analysis confirms that the vast majority of cases which are referred to the CPS are not prosecuted. Out of the 192 cases referred to the CPS between 2007-2018, only 12 resulted in prosecutions, thus representing 6% of the total number. Whilst there does appear to have been a spike in prosecutions in 2014, numbers have been consistently low in the period before and after that, amounting to an average across this time period of 1 prosecution per year. The overall number of referrals to the CPS also increased between the period 2011-2017. Although the reasons for this are not fully understood, it is likely that greater awareness from the police of the need to refer and also better record keeping during this period are important factors. We found no evidence that cases were investigated without merit, although the sample of cases which we examined was relatively small (10% of the total). Given that only 12 out of 192 cases ended up being prosecuted, the question of whether all other cases merited referral to the SCU or could be managed more efficiently by the police remains to be fully examined. Concern has been expressed about the length of time taken to make decisions in these cases, and the data collected here, which has not previously been collated and published, confirms that these cases do take do a considerable amount of time (an average of 17 months for FCT decisions and 7 months for EIA not to prosecute.) There are a number of reasons which enable us to better understand why these cases take time and which also make it difficult to identify ways of reliably reducing delay. However, we consider that the four recommendations which we make in this report could help the efficient handling of such cases. Improving police training, ensuring a consistent usage of the description of GNM, standardising elements of expert letters of instruction and designing specific offence guidance are all realistic recommendations which if properly implemented would potentially improve the clarity, consistency and confidence of decision making in these challenging cases. More detailed discussion of how this might be achieved, and a consideration of the implications for key actors in the Criminal Justice System, will be the subject of further follow on publications.