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# Doctors Are Aggrieved— Should They Be? Gross Negligence Manslaughter and the Culpable Doctor

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## Abstract

Doctors may also be criminals. Mercifully, this is a rare event but no health professional is infallible, mistakes happen and the challenge is to distinguish inadvertence from wilful disregard for the consequences. Healthcare professionals are uneasy about the readiness of the current law to attribute criminal responsibility accompanied by a failure to recognise the highly pressurised context in which sub-standard practice occurs. This article argues that the offence of gross negligence manslaughter is improperly defined and fails to target those doctors whom society should criminalise. Alternatives to gross negligence manslaughter to include culpable homicide adopted in Scotland and the major departure test favoured by New Zealand are considered before advocating a more radical approach—the sliding scale of negligence. Using existing tests in civil and administrative law, a more objective test of gross negligence is proposed, with culpability as a mandatory requirement for a doctor to be convicted of a crime. It is contended the law must move away from the stance a patient's death is required for medical negligence to become a crime, an outcome bias, to a conduct biased offence. There is no underlying reason why culpable gross negligence causing serious harm should not also be subject to criminal sanction. The recent sentencing guidelines demonstrate the law is sophisticated enough to distinguish reprehensible conduct from careless behaviour. It is now time for the legal test to also acknowledge all the circumstances of the alleged crime.

## Keywords

Gross negligence manslaughter, negligence, culpability, moral luck

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## Introduction—Gross Negligence Manslaughter and Doctors

The criminal doctor makes for a good story.<sup>1</sup> The fall and resurgence of Drs David Sellu and Hadiza Bawa-Garba has been as dramatic as it has been controversial.<sup>2</sup> Two previously anonymous medical professionals who found themselves not only under the media spotlight and labelled a criminal, but in the case of David Sellu incarcerated in a Belmarsh cell. Their very personal stories have reignited the debate whether doctors should be subject to the criminal law and more particularly whether doctors should, and if so how, be prosecuted for gross negligence manslaughter. In a speech given to the Medico-Legal Society, Dr Michael Powers QC, responding to concerns that prosecutions take place ‘at the least excuse’, strongly advocated the role of the criminal law, commenting:

‘We have got to have an element of control over excessively bad behaviour . . . society has the right to control bad professional care’. Adding, ‘whether or not a doctor is going to find himself on a manslaughter charge will really depend on how much thought, how much care and how much attention he is giving to what he does . . . The cases where we have seen convictions are cases which stick out like a barn door’.<sup>3</sup>

Some writers argue recent convictions have occurred where the barn door was ajar rather than gaping open.<sup>4</sup> If Dr Powers’ contention is correct, and bad clinical care should be prosecuted, it is necessary to address what conduct should be caught by the criminal law, as opposed to sub-standard conduct that should be left to the civil courts or professional tribunals. More specifically, the law must define the standard of culpability deserving of criminal sanction.

The grounds of doctors’ concerns are broadly that the law of gross negligence manslaughter is arbitrary, and even the very limited prosecutions are counterproductive if doctors remain unsure as to what it is they are doing so badly wrong that they may end up in prison. Doctors’ grievances can perhaps be broken down into two elements:

First, the current offence does not identify the ‘bad’ doctors; it unearths negligent doctors whose patients are unlucky enough to die. The scope of the offence is *uncertain*.

Second, professionals acting in good faith should not be labelled ‘criminals’. The element of intentionally making a bad choice, the prerequisite *mens rea* of all serious crimes, is often unclear or even absent. This *culpability* ingredient of the offence is poorly defined.

Beginning with an overview of the offence of gross negligence manslaughter and a critique of the current judicial approach, this article addresses what form an alternative test might take. Brief consideration is given to the law in other jurisdictions, the Scottish offence of culpable homicide and New Zealand’s major departure test, before exploring further the circumstances for negligent conduct to be considered culpable and the foundations for a new direction. Pivotal to this discussion is the distinction between an error and a violation and, it is maintained, the criminalisation of negligent conduct should only occur when the defendant is aware of a risk, elects to run that risk and had the opportunity to act differently. The debate then takes a more radical turn and proposes a new test, the sliding scale of negligence. By bringing civil and criminal law principles together, the bar between simple negligence and gross negligence is drawn with greater clarity, leaving the question of culpability to be determined separately along the lines recently espoused by the Sentencing Council. Sentencing guidelines, and the potential widening of the offence to include culpable conduct causing serious harm, not just death, are finally considered.<sup>5</sup>

1. M Brazier, S Devaney, D Griffiths, A Mullock and H Quirk, ‘Improving Healthcare Through the Use of Medical Manslaughter? Facts, Fears and the Future’ (2016) 22(5–6) *Clinical Risk* 88–93, 89.

2. *R v Bawa-Garba* [2016] EWCA Crim 1841; *R v Sellu* [2016] EWCA Crim 1716.

3. Dr M J Powers QC, ‘Manslaughter—How Did We Get Here?’ (2005) 73(4) *Medico-Legal Journal* 123–134, 128.

4. See A Alghrani, M Brazier, A Farrell, D Griffiths and N Allen, ‘Healthcare Scandals in the NHS: Crime and Punishment’ (2011) 37 *Journal of Medical Ethics* 230–232; J Vaughan, O Quick and D Griffiths, ‘Medical Manslaughter: Where Next’ (2018) *Bulletin of the Royal College of Surgeons of England*, 100 (6), pp. 251–254.

5. See later discussion; ‘Moral Luck’ and Sentencing—The Final Bastion.

In conclusion, this article contends that the current offence is inadequate and an alternative test that targets only the most serious of violations is required.<sup>6</sup> More controversially, to counteract the injustice caused by ‘moral luck’, the scope of the offence should be widened to include culpable conduct causing serious harm, not just death.<sup>7</sup>

## The Offence of Gross Negligence Manslaughter

Gross negligence manslaughter, particularly among the medical profession, has been the subject of much criticism.<sup>8</sup> The current offence survived the Law Commission review of 2006, which maintained that the defendant’s conduct should be compared with that of the hypothetical ‘reasonable person’<sup>9</sup> and has only been subject to minor modifications since the modern offence took shape in 1995.<sup>10</sup> Before considering the ingredients of the offence and those elements which generate disquiet among doctors, it is necessary to set out a brief exposition of the history and development of the offence to its present configuration.

### Tort to Crime: Negligence to Gross Negligence

Occasionally, professionals cause fatal harm to people to whom they owe a duty of care by falling so far below a standard that the matter becomes one of interest to the state. Lord Hewart addressed this almost 100 years ago in *R v Bateman*.<sup>11</sup>

Dr Bateman attempted the delivery of a breech baby with forceps and then, having failed, tried to turn the baby manually to effect a more favourable presentation. Ultimately, the child was stillborn and the mother left with a number of internal injuries from which she died.<sup>12</sup> The judge in the court of first instance directed the jury to find Dr Bateman guilty of gross negligence manslaughter if they found he had been negligent.<sup>13</sup> The conviction was quashed by the Court of Appeal and, in giving his judgment, Lord Hewart made some notable points:

In the civil action, if it is proved that A fell short of the standard of reasonable care required by law, it matters not how far he fell short of that standard. The extent of his liability depends not on the degree of negligence, but on the amount of damage done. In the criminal court, on the contrary, the amount and degree of negligence are the determining question. There must be *mens rea*.<sup>14</sup>

If the Crown wanted to convict Dr Bateman of a criminal offence:

6. See later and more generally A Merry and W Brookbanks, *Merry and McCall Smith’s Errors, Medicine and the Law* (2nd edn ch 4, CUP, Cambridge) 41 et seq.
7. See later discussion of ‘Moral Luck’—Should the Outcome Matter More Than the Violation?
8. See J Montgomery, ‘Medicalizing Crime—Criminalizing Health The Role of Law?’ in Charles Erin and Suzanne Ost (eds), *The Criminal Justice System and Health Care* (OUP, Oxford 2007) 257; O Quick, ‘Prosecuting “Gross” Medical Negligence: Manslaughter, Discretion, and the Crown Prosecution Service’ (2006) 33 *J Law and Soc* 421; O Quick, ‘Medicine, Mistakes and Manslaughter: A Criminal Combination?’ (2010) 69 *CLJ* 186; A McCall Smith, ‘Criminal Negligence and the Incompetent Doctor’ (1993) 1 *Med L Rev* 336; M Brazier and N Allen, ‘Criminalising Medical Malpractice’ in Erin and Ost (eds), *The Criminal Justice System and Health Care* (OUP, Oxford 2007) 15–27.
9. The Law Commission (Law Com No 304) MURDER, MANSLAUGHTER AND INFANTICIDE Project 6 of the Ninth Programme of Law Reform: Homicide. At 3.59 Gross negligence manslaughter can be committed even when D was unaware that his or her conduct might cause death, or even injury. This is because negligence, however gross, does not necessarily involve any actual realization that one is posing a risk of harm: it is a question of how glaringly obvious the risk would have been to a reasonable person.
10. See later *R v Adomako* [1995] 1 AC 171; *R v Misra and Srivastava* [2004] EWCA Crim 2395; *R v Rudling* [2016] EWCA Crim 741.
11. *R v Bateman* [1925] All ER 45, 48.
12. Her uterus was severely damaged and delivered along with the placenta.
13. *Bateman* (n 11).
14. *Ibid* at 47.

[T]he prosecution must prove the matters necessary to establish civil liability . . . and . . . must satisfy the jury that the negligence or incompetence of the accused went beyond a mere matter of compensation and showed such disregard for the life and safety of others as to amount to a crime against the State and conduct deserving punishment.<sup>15</sup>

For Lord Hewart, *mens rea* was a vital ingredient for a conviction of gross negligence manslaughter. The House of Lords affirmed Lord Hewart's general description of the offence of gross negligence manslaughter in *R v Adomako*.<sup>16</sup>

Dr Adomako, a locum anaesthetist, failed to perform basic monitoring of his patient during an operation and then failed to react properly to clear evidence of inadequate ventilation until too late.<sup>17</sup> His patient subsequently died.

The Court of Appeal addressed the question of the true legal basis for involuntary manslaughter by breach of duty. This was deemed to be gross negligence as opposed to recklessness.<sup>18</sup> Helpfully, gross negligence, the crux of the matter, was defined as proof of any of the following states of mind:

- (a) indifference to an obvious risk of injury to health;
- (b) actual foresight of the risk coupled with the determination nevertheless to run it;
- (c) an appreciation of the risk coupled with an intention to avoid it but also coupled with such a high degree of negligence in the attempted avoidance as the jury consider justifies conviction;
- (d) inattention or failure to avert to a serious risk which goes beyond 'mere inadvertence' in respect of an obvious and important matter which the defendant's duty demanded he should address.<sup>19</sup>

Adomako's case was then referred to the House of Lords which upheld his conviction and agreed that gross negligence was the test of criminality.<sup>20</sup> Disappointingly, there was little comment on what turned simple negligence into gross negligence. Of this, Lord Mackay said:

This will depend on the seriousness of the breach of duty committed by the defendant in all the circumstances in which the defendant was placed when it occurred. The jury will have to consider whether the extent to which the defendant's conduct departed from the proper standard of care incumbent upon him, involving as it must have done a risk of death to the patient, was such that it should be judged criminal.<sup>21</sup>

These remarks seemingly left open the question of how, prospectively, a doctor can determine whether a medical error could result in a prison sentence; an unease that would be felt keenly for all those involved in the care of patients with potentially fatal illnesses.

More recently, Sir Brian Leveson summarised the five critical components of the offence in *R v Rudling* as,

- (a) the defendant owed a duty of care to the deceased;
- (b) the defendant was in breach of that duty of care;
- (c) it was reasonably foreseeable that the breach gave rise to an obvious and serious risk of death;

15. *Ibid.*

16. *Adomako* (n 10) at 187 *per* Lord Mackay.

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

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

19. *Ibid* at 944.

20. *Adomako* (n 10), 188.

21. *Ibid* at 187.

- (d) the negligence did in fact cause death;
- (e) the negligence which caused death was ‘so bad in all the circumstances’ as to be adjudged criminal.<sup>22</sup>

This approach was confirmed in *R v Rose*.<sup>23</sup> In *Rose*, the defendant optometrist negligently failed to examine the retinas of a child.<sup>24</sup> Had she done so, she would have identified papilloedema, leading to a diagnosis of hydrocephalus, which, left untreated, is fatal.<sup>25</sup> The defendant’s failure to examine the eyes of the child resulted in his condition being undiagnosed and he died some five months later. Diagnosing papilloedema and failing to take any further action would have been grossly negligent, but in failing to examine the eye at all the optometrist would not have been aware of ‘a serious and obvious risk of death’ at the time of the breach of duty.<sup>26</sup> This, Sir Brian Leveson judged, precluded the offence of gross negligence and Rose was found simply negligent.

*Rose* suggests that the clinician who negligently fails to examine an apparently moderately sick patient will fare better than the conscientious clinician who attends the same patient but fails to observe that they are, in fact, very sick.<sup>27</sup>

Herein lies the two heads of medical concern about the offence of gross negligence manslaughter: certainty and the degree of culpability required to merit imprisonment.

**Certainty.** Article 7 of the European Convention on Human Rights (ECHR) prohibits punishment without law. In essence, if the crime cannot be defined sufficiently for a defendant to have had prior knowledge of it, they cannot be convicted. This lack of certainty formed the core of the appeal in *R v Misra and Srivastava*.<sup>28</sup> Judge LJ opined that the law was sufficiently certain to uphold a conviction of gross negligence manslaughter.<sup>29</sup> The principle elements of the offence of gross negligence manslaughter are certain but the circularity generated by a definition of gross negligence being criminal if gross and gross if criminal had previously been outlined as a problem by Lord Mackay in *Adomako*, as was acknowledged by Judge LJ in *Misra*:

It is true that to a certain extent this involves an element of circularity . . . 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 judgment to a criminal act or omission . . .<sup>30</sup>

Effectively, this leaves a question of law to the jury; when is negligence sufficiently gross to be adjudged criminal? The function of a jury is to deliberate questions of fact, not law, and the role of the

22. *Rudling* (n 10) at para 18 per Sir Brian Leveson.

23. *R v Rose* [2017] EWCA Crim 1168, at para 77 per Sir Brian Leveson.

24. Opticians Act 1989 s 26(1)(a), ‘. . . it shall be his duty—(a) to perform such examinations of the eye for the purpose of detecting injury, disease or abnormality in the eye or elsewhere as the regulations may require . . .’.

25. Papilloedema is swelling of the optic disc at the back of the eye and is associated with increased pressure within the brain. It is fairly easy to see with basic medical instruments and almost always indicates serious underlying pathology.

26. *Rose* (n 23) at para 80 per Sir Brian Leveson. Commenting on the test of reasonable foreseeability his Lordship said, ‘the question of available knowledge and risk is always to be judged objectively and prospectively at the moment of the breach, not but for the breach.’

27. This is the point made by Cath Crosby, ‘Gross Negligence Manslaughter Revisited: Time for a Change of Direction?’ (2020) 84(3) *J Crim L* 228–45, at 244. Commenting on the implications of the decision in *Rose* she notes that it ‘exculpates where D is ignorant of any risk *only* because they have failed to fulfil their duty’. We discuss this further below.

28. [2004] EWCA Crim 2375. In *R v Misra and Srivastava*, the two defendant doctors negligently failed to diagnose and treat a patient with sepsis who subsequently died. They unsuccessfully appealed (invoking art 7 of the ECHR that a jury decision as to what turned simple negligence into criminal negligence was uncertain enough to make their conviction unsafe).

29. *Ibid* at paras 58,64 per Judge LJ. Leave to appeal to the House of Lords was refused.

30. *Adomako* (n 10) at 187.

judge is to direct the jury on a point of law. If, as Lodge observes, ‘following the imposition of a gross negligence manslaughter charge, the jury is tasked with filtering out those failures deserving of criminal sanction’,<sup>31</sup> any degree of certainty is highly improbable when it is dependent on the subjective opinion of a jury.

Judge LJ was dismissive of this approach and commented:

The question for the jury is not whether the defendant’s negligence was gross, and whether, additionally, it was a crime, but whether his behaviour was grossly negligent and consequently criminal.<sup>32</sup>

This, as Ashworth commented, ‘is a distinction without a difference and . . . it should not be the last word on the subject’.<sup>33</sup>

What is certain about the current offence is that if doctors cause death through negligence they may end up in prison, even if they did their best with the resources available.<sup>34</sup> A doctor is reliant on the jury finding that their error was blameless, relying only on the performance of expert witnesses and their own intuition.<sup>35</sup> There is no means of avoiding the full force of the criminal law other than avoiding contact with sick patients. This is not an option for the conscientious clinician fulfilling a vital role in society<sup>36</sup> but was the very message projected by Leveson’s judgments in *R v Rose*<sup>37</sup> and *R v Rudling*.<sup>38</sup>

Laird is highly critical of the judgment in *Rose*, questioning who is the more blameworthy, an optometrist who performs an examination but misses an obvious sign or an optometrist who neglects to carry out any examination whatsoever?<sup>39</sup> Both are at fault and both, ultimately, seal the fate of the patient. Some clarification was given in *R v Winterton*.<sup>40</sup> Here, the defendant, a construction manager, was convicted of manslaughter when a trench collapsed on a labourer. In upholding his conviction, the Court of Appeal held that there was an obvious and serious risk of death caused by the trench which should have been apparent to Winterton. If Winterton alleged he was unaware of the risk, the court

31. A Lodge, ‘Gross Negligence Manslaughter on the Cusp: The Unprincipled Privileging of Harm Over Culpability’ (2017) 81 *J Crim L* 125 at 127.

32. *Misra* (n 28) at para 62 per Judge LJ.

33. A Ashworth and J Horder, *Principles of Criminal Law* (7th edn OUP, Oxford 2013), 293.

34. In *Bawa-Garba v GMC* [2018] EWCA Civ 1879, it is apparent that the Appeal Court failed to explore ‘all the circumstances’ leading to the death of Jack Adcock. At paras 74 and 75, the court stated ‘. . . systemic failures on the part of the Trust were only ever of peripheral relevance to the guilt or absence of guilt of Dr Bawa-Garba for gross negligence manslaughter’ and, quoting the trial judge, Nicol J ‘There was a limit to how far these issues could be explored in the trial’. Worryingly, ‘both the prosecution and the defence agreed that the report commissioned by the Trust, following Jack’s death, which investigated systemic failures on the part of the Trust and made recommendations for improvement, should not be placed before the jury’. Ian Freckleton commenting on Dr Bawa-Garba’s case observes that ‘It was truly a situation in which her own errors in acuity and focus lined up with a series of other “holes in the Swiss cheese. . .”’, ‘Regulation of Substandard Medical Practice: Lessons From the Bawa-Garba Case’ (2018) 25 *JLM* 603 at 623. Freckleton refers to J Reason ‘Human Error: Models and Management’ (2000) *BMJ* 768.

35. O Quick, ‘Expert Evidence and Medical Manslaughter: Vagueness in Action’ (2011) 38 *J. Law & Soc* 496, at 516. In Oliver Quick’s small study of 10 medical experts, he concluded that ‘such cases rely heavily on the subjective interpretations and judgments of experts applying their own standards to cases under review’.

36. The social utility of professionals taking calculated risks in difficult circumstances with limited time to make full assessments has long been recognised. See *Watt v Herts CC* [1954] 1 *WLR* 835.

37. It is suggested negligence protects against gross negligence, see later *Barnett v Chelsea & Kensington Hospital* [1969] 1 *QB* 428; *Rose* (n 23).

38. *Rudling* (n 10).

39. K Laird ‘The Evolution of Gross Negligence Manslaughter’ (2018) 1 *Arch Rev* 6–9. See also *Whitehouse v Jordan* [1981] 1 *WLR* 246 para 263D-F per Lord Fraser, ‘The true position is that an error of judgment may, or may not, be negligent; it depends on the nature of the error. If it is one that would not have been made by a reasonably competent professional man professing to have the standard and type of skill that the defendant held himself out as having, and acting with ordinary care, then it is negligent. If, on the other hand, it is an error that such a man, acting with ordinary care, might have made, then it is not negligent’.

40. *R v Winterton (Andrew)* [2018] EWCA Crim 2435.

reasoned that he was wilfully blind or ignorant, which was sufficient to make him liable. Why, as Laird observes, if this defendant was liable for wilful ignorance was Rose also not liable?<sup>41</sup> The Appeal Court, however, maintained that *Rose* was factually very different; in *Rose* the risk would only have been obvious had the breach not occurred or as Laird sums up,

if the risk would only have been obvious had the defendant complied with his or her duty of care, then there can be no liability.<sup>42</sup>

In *Winterton*, the risk of the collapsing trench was obvious, the defendant was therefore liable. By contrast in *Rose*, the risk of hydrocephalus was not outwardly apparent in a seemingly healthy patient. The risk was only obvious if Rose had examined her patient.<sup>43</sup> As Laird observes, no matter how negligent the lack of testing or examination of an ostensibly healthy patient, there will be no criminal liability. This leads him to conclude, ‘A divergence seems to be taking place in terms of how gross negligence manslaughter applies to healthcare professionals as opposed to others upon whom the law imposes a duty of care’.<sup>44</sup>

**Culpability.** The criminal law punishes individuals who have personally offended the values of the state. Those values ordinarily apply to all citizens without favour irrespective of the occupation of the actor. A professional is required to have a specific skill set as determined by the profession’s regulator. A failure to meet the regulator’s standard can result in both legal and professional sanctions. Here, it is the person as a professional who is punished, not the person as an individual. For a doctor, the General Medical Council (GMC) governs the standards required of the doctor, as a professional.<sup>45</sup> The GMC cannot fine, imprison or impose a gaol sentence on an individual.<sup>46</sup> Underperformance, and subsequent regulatory sanction, applies solely to the person in their professional role and not the person as an individual.

Manslaughter is a crime committed by an individual in either a personal or professional capacity. Professional underperformance leading to negligently caused harm is a matter for the GMC and the civil courts. Personal criminal activity causing harm is an issue for the criminal law. The professional is reprimanded by the regulator, the complainant is compensated by the civil courts and the criminal is punished by the state. These distinctions are important as blurring these divisions risks criminalising the individual solely for professional underperformance. There must, it is argued, be a degree of individual, personal culpability for a manslaughter conviction.<sup>47</sup>

English law contends that negligence, ‘which went beyond a mere matter of compensation’ may be regarded as criminal and provides the necessary *mens rea* exclusively for the offence of manslaughter with no requirement to evaluate the defendant’s ‘state of mind’.<sup>48</sup> Gross negligence, however, does not provide the necessary *mens rea* for any other harm. If a surgeon is grossly negligent and removes the wrong limb, on the assumption that this was not a deliberate act or reckless conduct, the negligent

41. K Laird, ‘Gross Negligence Manslaughter: *R. v Winterton (Andrew)*’ (2019) 4 *Crim LR* 336–39.

42. *Ibid* at 339.

43. This line of reasoning is seen in *Rudling* (n 10) where Sir Brian Leveson P said, ‘At the time of the breach of duty, there must be a risk of death, not merely serious illness; the risk must be serious; and the risk must be obvious (para 39).

44. Laird, (n.41) 339.

45. Through the delegated authority of the Medical Act 1983.

46. There are a range of GMC sanctions that may be imposed to include a warning, condition or referral to the Medical Practitioners Tribunal Service which has the power to restrict, suspend or revoke a doctor’s registration.

47. Ashworth contends that ‘no person should be liable to imprisonment without proof of sufficient fault’, Ashworth (n 33) at 168.

48. *Adomako* (n 10), 179. On this point in *AG Ref (No 2 of 1999)* [2000] QB 796, at 809 the court said, ‘Although there may be cases where the defendant’s state of mind is relevant to the jury’s consideration when assessing the grossness and criminality of his conduct, evidence of his state of mind is not a prerequisite to a conviction for manslaughter by gross negligence’.



surgeon will not face criminal sanction.<sup>49</sup> Similarly, if the same surgeon is ‘lucky’ and their patient survives, they will evade the criminal law.<sup>50</sup>

A doctor who is aware that they are taking an unnecessary risk is reckless. Short of outright intent to cause harm, this is the most culpable state of mind associated with gross negligence manslaughter. However, whether a doctor is deserving of a criminal conviction by making an inadvertent mistake that results in the death of a patient, is not as straightforward.

Doctors maintain that it is unfair to use negligence alone, however gross, to convict them of a criminal offence; there must also be demonstrable culpability. In the alternative, if gross negligence *per se* does provide the necessary *mens rea*, then this test should be available in all cases of harm caused by gross negligence, to do otherwise would discriminate against the severely injured victim.

Herein lies the essence of the doctor’s dilemma: Personal and professional integrity is not enough if you happen to be unlucky. All doctors make mistakes. Negligence occurs when doctors fall below their professional standards. Negligence implies a degree of inadvertence whether caused by bad luck, fatigue, ill health or factors that are morally less excusable such as indifference or laziness. Doctors accept being found negligent if they cause harm to a patient by falling below an agreed standard; what is less palatable is being found criminally responsible if their intentions were not additionally culpable. The idea that inadvertence lacks culpability suggests that ‘ignorance’ protects against criminal conviction but the thrust of Powers’ complaint<sup>51</sup> is that *something* needs to be done about ‘excessively bad behaviour’, whatever the cause.<sup>52</sup> Imposing ‘strict liability’ and dispensing with ‘*mens rea*’ altogether is to revert back to the court of first instance in *Bateman* (negligence plus death equals gross negligence) or adopt the situation in New Zealand until 1997.<sup>53</sup> This is to be resisted and demonstrable culpability unearthed for such a serious offence.

It may be possible to be culpable while also inadvertent, for the following reason: If a doctor has the capacity to make a different choice but declines to do so, this is blameworthy.<sup>54</sup> This is not the same as having made a conscious choice at that particular time; it merely reflects the doctor’s capacity to have acted differently. This state of mind is culpable by virtue of being unexercised capacity. Not engaging one’s full capacity is, arguably, morally wrong if serious harm may result.<sup>55</sup> For Dr Bawa-Garba, this ‘unexercised capacity’ translated as an ability to have refused the onerous duties asked of her, given her recent return to work, staff shortages, absence of a senior colleague, etc.<sup>56</sup> She also had the capacity to request help during the day but failed to fully exercise this. She was ‘far from being a bad person’<sup>57</sup> but demonstrated a degree of culpability as she chose not to engage herself to her optimum capacity. Whether this degree of culpability is deserving of criminal sanction is questionable. What is incontrovertible is the cost, in career terms, to Dr Bawa-Garba of exercising her right to choose not to work on

49. Offences Against the Persons Act 1861, s 20. For a discussion of recklessness see further F Stark *Culpable Carelessness: Recklessness and Negligence in the Criminal Law*, (CUP, Cambridge 2016).

50. The concept of ‘moral luck’ is discussed later.

51. Powers (n 3) at 127.

52. Lord Diplock’s sentiments ran along similar lines when he said ‘where the subject matter . . . is the regulation of a particular activity involving potential danger to public health, safety or morals . . . , the court may feel driven . . . to impose by penal sanctions a higher duty of care on those who choose to participate and to place upon them an obligation to take whatever measures may be necessary to prevent the prohibited act, . . . in order to fulfil the ordinary common law duty of care. But such an inference is not lightly to be drawn . . . unless there is something that the person . . . may be expected to influence or control, which will promote the observance of the obligation’ in *Sweet v Parsley* [1970] AC 132 (HL) at 163.

53. This is one of the potential alternatives considered to the present test and discussed later.

54. HLA Hart, ‘Negligence, Mens Rea and Criminal Responsibility’ in *Punishment and Responsibility: Essays in the Philosophy of Law* (2008, OUP, Oxford) 136–157. See also M Moore and H Hurd, ‘Punishing the Awkward, the Stupid, the Weak and the Selfish: The Culpability of Negligence’ (2011) 5 *Criminal Law and Philosophy* 147.

55. *Ibid.*

56. *Bawa-Garba* (n 2). Dr Bawa-Garba was recently convicted of the manslaughter of an already very sick child.

57. Paraphrased from the trial judge sentencing Drs Sullman and Prentice, quoted in Brazier and Alghrani, ‘Fatal Medical Malpractice and Criminal Liability’ (2009) 25 *Journal of Professional Negligence* 51, at 56.

that ward or to disturb her supervising consultant who was in another hospital. This, however, opens up a whole Pandora's box of questionable 'medical establishment conventions' and falls outside the remit of this article.<sup>58</sup>

### Other Options—Is There a Better Way?

The preceding paragraphs have provided a brief insight into the problems with the current law. Finding a replacement test is an altogether trickier task. The Law Commission's proposed replacement of killing by gross carelessness was dismissed by Quick as 'nothing more than a linguistic modernization of the status quo', which he contends has failed to 'address the fundamental objection to negligence-based criminal liability'.<sup>59</sup> He favours the test put forward by Tadros which focuses on the breach of duty of the perpetrator either by failing to investigate risks or by being wilfully blind to the existence of a risk.<sup>60</sup> However, this approach would possibly incarcerate doctors such as Prentice and Sullman who failed to investigate the risks of injecting drugs intrathecally even though their fatal omission to investigate risk was borne though ignorance, not indifference.<sup>61</sup> Objectively, by way of contrast to the hypothetical 'reasonable person', they were reckless but subjectively, given their inexperience and all the circumstances they found themselves in, they were merely negligent. A more satisfactory stance is that taken by Mullock who maintains that the appropriate basis for liability is subjective recklessness<sup>62</sup> or McCall Smith who contends that prosecutions should only occur when there is reckless conduct and the perpetrator 'deliberately and culpably took a risk with their patients'.<sup>63</sup> Along similar lines, Brazier opines that 'only such conduct pursued with disregard for the life of others should merit punishment'.<sup>64</sup> More recently, Crosby advocates that gross negligence manslaughter is replaced with reckless manslaughter using a capacity-based approach that emphasises the need to 'appreciate a risk and the context in which the proscribed conduct occurred'. While the move towards greater recognition of 'all the circumstances' is to be welcomed, a test founded in negligence would, it is contended, more clearly define the error from the violation.<sup>65</sup>

The case for a test of subjective recklessness has always been highly persuasive but has thus far failed to gain traction outside of academia. Therefore, having outlined the problems with English law and gross negligence manslaughter, the debate now broadens to explore a wider range of alternatives to the present regime. Beginning with a review of two jurisdictions' approach to gross negligence manslaughter, the discussion then advocates a new model, grounded in clinical experience and adhering to already established legal principles, which may yet salvage an offence labelled as 'something of a dog's breakfast'.<sup>66</sup>

### Lessons From Over the Seas and Closer to Home

Scotland and New Zealand have adopted very different stances to gross negligence manslaughter. Scottish law places culpability at the heart of the test for culpable homicide; *mens rea* is centre stage.

58. Junior doctors are trainees who are supposed to be under supervision (Dr Bawa-Garba, Dr Prentice, Dr Sullman, Dr Misra). The consultant who supervised Dr Bawa-Garba from a separate hospital was made aware of Jack Adcock's highly abnormal blood results but chose not to see the child. The Courts and GMC chose to regard this as her failure to engage him in the management of a patient who was, ultimately, under his care.

59. O Quick, 'Medical Manslaughter: The Rise and Replacement of a Contested Crime' in Erin and Ost (n8) at 47.

60. See V Tadros, 'Recklessness and the Duty to Take Care' in S Shute and AP Simester (eds), *Criminal Law Theory: Doctrines of the General Part* (OUP, Oxford 2002) 227–258, at 255.

61. *Prentice and Sullman* (n 17)

62. A Mullock, 'Gross Negligence (Medical) Manslaughter and the Puzzling Implications of Negligent Ignorance: *Rose v R* [2017] EWCA Crim 1168' (2018) 26(2) *Med L Rev* 346–356.

63. McCall Smith (n 8) at 349.

64. Brazier and Allen (n 8) at 27.

65. Crosby (n 27), 245. Errors and violations are discussed further below.

66. Moore and Hurd (n 54) at 192.

New Zealand has all but abandoned the criminal law in its regulation of doctors. In contrast, English law has repeatedly stressed that the defendant's state of mind may not be relevant and that the criminal law has a role in the regulation of doctors.<sup>67</sup> It is difficult to see how all three positions can be right. The paragraphs below examine the Scottish and New Zealand regimes more closely.

## Scotland

In Scottish criminal law, there is no such offence as gross negligence manslaughter. There is culpable homicide, which is either voluntary or involuntary.<sup>68</sup> These broadly resemble English voluntary and involuntary manslaughter. It is an involuntary culpable homicide which would, perhaps, capture the essence of gross negligence manslaughter.<sup>69</sup>

The *mens rea* of this type of unintentional, but nevertheless, culpable homicide is 'gross, or wicked negligence, something amounting, or at any rate analogous, to an indifference to consequences'.<sup>70</sup>

Nevertheless, in keeping with subjective recklessness, it is emphasised that an analysis of defendant's state of mind is crucial to any conviction:

[*Mens rea* is, and remains, a necessary and significant element in the crime of ('lawful act') culpable homicide. That element may . . . be proved in various ways, including proof by inference from proven facts. But it is . . . erroneous to suppose that the actual state of mind of a person accused of culpable homicide of this kind can be ignored and guilt or innocence determined solely on the basis of proof that the conduct in question fell below an objectively set standard.<sup>71</sup>

This constitutes a degree of contemporaneous awareness, on the part of the defendant, that they were taking a risk that would be considered unnecessary by reference to a 'reasonable person'. Inadvertence, unless grounded in an intention to be unaware of risks, will not suffice.<sup>72</sup> In most Anglo-American jurisdictions, the difference between recklessness and negligence hinges on this contemporary awareness of risk.<sup>73</sup>

The English offence recognises that recklessness contains all the ingredients required of gross negligence and that mere negligence is not enough. However, the Scottish system does nothing to fill the gap between mere negligence and recklessness. Gross negligence manslaughter includes not only a

67. See *AG Ref* (n 48); *Misra* (n 28).

68. The law is currently under review but the proposed changes mainly concern the employers of those found guilty of the offence. See Scottish Parliament website <[www.parliament.scot/parliamentarybusiness/Bills/110169.aspx](http://www.parliament.scot/parliamentarybusiness/Bills/110169.aspx)> accessed 12 June 2020.

69. For a fuller exposition see, eg, C McDiarmid, 'Killings Short of Murder: Culpable Homicide in Scots Law' in A Reed, M Bohlander, N Wake, E Engleby and V Adams (eds), *Homicide in Criminal Law: A Research Companion (Substantive Issues in Criminal Law)* (Routledge, London 2018) 21–36.

70. *Transco v HM Advocate* (2004) JC 29, at [33] *per* Lord Osborne.

71. *Ibid* at [38] *per* Lord Hamilton, in keeping with Lord Hewart's requirement for demonstrable *mens rea* in *R v Bateman* (n 11).

72. *Moore and Hurd* (n 54) at 192. Also *R v Reid* [1992] 3 All ER 673.

73. The following extract from the American Model Penal Code (MPC) illustrates a convergence among Anglo-American jurisdictions of what Stark calls a Standard Account of culpability: See further F Stark, *Culpable Carelessness: Recklessness and Negligence in the Criminal Law* (CUP, Cambridge 2016) (n 40) [65].

**Recklessly.** A person acts recklessly with respect to a material element of an offence when he consciously disregards a substantial and unjustifiable risk that the material element exists or will result from his conduct. The risk must be of such a nature and degree that, considering the nature and purpose of the actor's conduct and the circumstances known to him, its disregard involves a gross deviation from the standard of conduct that a law-abiding person would observe in the actor's situation.

**Negligently.** A person acts negligently with respect to a material element of an offence when he should be aware of a substantial and unjustifiable risk that the material element exists or will result from his conduct. The risk must be of such a nature and degree that the actor's failure to perceive it, considering the nature and purpose of his conduct and the circumstances known to him, involves a gross deviation from the standard of care that a reasonable person would observe in the actor's situation.

conscious disregard but also inadvertence in respect of an obvious matter which the defendant should have addressed.<sup>74</sup> The parallels with subjective and objective recklessness are plain to see: Did the defendant foresee the risk and take it anyway (subjective) or was the defendant blind to the risk which would have been blatantly obvious to another professional in the same position (objective)?<sup>75</sup>

Culpability is key to both Scottish and English law, but whereas the former only finds culpability in a contemporaneous conscious disregard, the latter regards manifestly poor performance as culpable in its own right.

There is another approach, which deals with fatal professional incompetence by mending the defendant as opposed to simply punishing them.

## New Zealand

Under New Zealand law, manslaughter is a type of culpable homicide which may be committed by an unlawful act, or an omission without lawful excuse to perform or observe a legal duty, or by both combined.<sup>76</sup> The ‘unlawful act’, must be a criminal offence and is identified as a breach of any Act, regulation, rule or by-law.<sup>77</sup> An ‘unlawful act’ usually, though not exclusively, relates to public safety. For an act to be regarded as unlawful there must be, (1) the corresponding mental state (*mens rea*) to render it an offence, and (2) the relevant act must be done without lawful justification or excuse. Where medical professionals are implicated in the death of a patient, and a police prosecution follows, a charge of manslaughter may be based on either an ‘unlawful act’ or the failure ‘to perform a legal duty’. However, the degree to which the defendant must have deviated from an accepted standard has seen substantial change in the last two decades. The case of *R v Yogasakaran*<sup>78</sup> was probably the catalyst for this change.

At the end of routine surgery, a patient bit down on their breathing tube and effectively cut off their own oxygen supply. This is not an unusual occurrence and many anaesthetists will insert a bite block to prevent this from happening. Other anaesthetists will simply wait until the biting stops and then remove the tube. Occasionally, the patient will bite so hard and for so long that the tube becomes occluded and they begin to turn blue. Dr Yogasakaran’s patient did just this so he quite reasonably decided to administer doxapram to hasten emergence from anaesthesia (and thus terminate the biting). Unfortunately, the ampoule he opened and administered in haste was dopamine and not doxapram. The two very different drugs had been erroneously put together in the same container by a third party. Dr Yogasakaran could not explain what had happened based on the assumption of doxapram administration, consequently he further examined the opened ampoules and volunteered the error he had made to the receiving intensive care team. Unfortunately, the patient had sustained fatal physiological stresses and died shortly later. Dr Yogasakaran’s honest mistake resulted in a patient death and Yogasakaran’s criminal conviction.

Yogasakaran committed his fatal blunder in 1987 and this was proceeded by a number of cases with varying degrees of culpability.<sup>79</sup> Naturally, there was widespread unease among the medical profession and after much lobbying, the Act was amended in 1997.

74. *Adomako* (n 10).

75. ‘It is clearly blameworthy to take an obvious and significant risk of causing injury to another. But it is not clearly blameworthy to do something involving a risk of injury to another if... one genuinely does not perceive the risk. Such a person may fairly be accused of stupidity or lack of imagination, but neither of those failings should expose him to conviction of serious crime or the risk of punishment. *R v G* [2003] UKHL 50 [32] *per* Lord Bingham.

76. Crimes Act 1961 (NZ) s 160(2).

77. Crimes Act 1961 (NZ) s 2(1).

78. *R v Yogasakaran* [1990] 1 NZLR 399.

79. A Merry, ‘When Are Errors a Crime?—Lessons From New Zealand’ in Erin and Ost (n 8) 67–97, at 75–77; *R v Morrison*, High Court, Dunedin, CR 7/91, 23 April 1991.

The Crimes Amendment Act 1997 added a new s 150A to the Crimes Act 1961. Liability for manslaughter by failure to perform a legal duty now required proof of a ‘major departure’ from the standard of care expected of a reasonable person.<sup>80</sup> Since 2012, the same threshold test now also applies in instances where manslaughter by an unlawful act is founded on proof of negligence. Effectively, as in England, this brings negligent acts or omissions under the same umbrella where there exists a duty of care.

Since 1997, when the ordinary negligence threshold was lifted to effectively one of gross negligence, there has been only one case of alleged medical manslaughter.<sup>81</sup> This case came following a period of 10 years (1996–2006) during which no health practitioner had been convicted of medical manslaughter, leading Professor Ron Paterson to suggest that there was ‘no realistic prospect of revival of the use of the criminal law in this area’.<sup>82</sup>

Although there have been a handful of prosecutions of health practitioners in New Zealand since the 1997 reforms, the place and usefulness of the criminal law in a medical context is now an increasingly rare event.<sup>83</sup> Prosecutions for medical manslaughter, it seems, have ‘all but ceased’.<sup>84</sup> However, since the changes in the Crimes Act, health professionals and providers have been encouraged to report any unintended, unexpected or unplanned events to the Health Quality & Safety Commission. The Commission runs an Adverse Events Learning Programme which reviews events and shares lessons learned in order to improve consumer safety.<sup>85</sup>

### *Comment on the Major Departure Test*

An enduring criticism of the gross negligence model, as outlined at the beginning of this article, is the very vagueness of the offence. Quick contends that the lack of certainty with the offence has resulted in an inconsistent approach to prosecutions which has been felt more keenly by those ‘operating in error-ridden activities who are exposed to risk of prosecution by virtue of their socially vital work, and often at the mercy of moral luck’.<sup>86</sup> The ‘major departure’ test has been described as a ‘good formulation and avoids any difficulties which might be thought to apply to the term “gross negligence”’.<sup>87</sup> This is true in so far that the ‘major departure’ test focuses on conduct rather than outcome, but it remains dogged by the same ambiguities and imprecision that have vexed the ‘gross negligence’ test; indeed, any model where a subjective epithet is applied. In New Zealand, however, the virtual abandonment of criminal prosecutions for medical manslaughter is evidence that they have seemingly adopted the view of Ron Paterson who maintains that most New Zealand patient advocacy groups, doctors and lawyers are now

80. This change in the law is illustrated in the decision of the New Zealand Court of Appeal in *R v Powell* [2002] 1 NZLR 152. In *Powell* whereby the ‘major departure’ test was held to apply not only to manslaughter by omission to perform a legal duty but also to manslaughter under s 160 (2)(a) by an unlawful act involving either carelessness or negligence.

81. That case, in 2006, did not involve a doctor but a midwife who was found not guilty for the management of a difficult breech delivery which resulted in the child’s death. See K Wallis, ‘Professional Accountability of Doctors in New Zealand’ (2013) 5(2) *Journal of Primary Health Care*.

82. R Paterson, *The Good Doctor* (Auckland University Press, Auckland 2012) at 51.

83. Merry and Brookbanks (n 6) at 315–18 and see R Paterson, ‘From Prosecution to Rehabilitation: New Zealand’s Response to Health Professional Negligence’ in D Griffiths and A Sanders (eds), *Bioethics, Medicine and the Criminal Law* (vol 2 CUP, Cambridge 2013) 244.

84. PDG Skegg, ‘Medical Acts Hastening Death’ in P Skegg and R Paterson (eds), *Health Law in New Zealand* (Thomson Reuters, Wellington 2015), 616.

85. See ‘Criminal Charges for Medical Error “Very Rare” in NZ, Says Legal Expert’ *Health Central/Pokapū Hauora* (16 August 2018) <<https://healthcentral.nz/manslaughtfhter-charges-for-medical-error-very-rare-in-nz-says-legal-expert/>> accessed 25 June 2020.

86. Quick, ‘Prosecuting “Gross” Medical Negligence’ (n 8) at 449.

87. New Zealand Medical Law Reform Group Submission to Justice and Law Reform Select Committee, Crimes Amendment Bill (No 5) 1996, ‘Medical Manslaughter’, submission 5.

agreed that the criminal law should only be used in healthcare settings in cases of deliberate harm or recklessness.

## A New Model—The Foundations

A criticism of the current offence is that it is not so concerned with the *contexts* in which negative events occur, but singularly focused on assessing responsibility for *discrete acts* of wrongdoing. Such a model is clearly inappropriate in assigning blame in medical settings, where context is everything. Ashworth contends that for conduct to be criminal there must be harm and culpability.<sup>88</sup> Harm requires no further discussion in the context of gross negligence manslaughter although as argued later, the justification of criminal liability should not be dependent on whether the patient lives or dies, but the conduct should be judged ‘in terms of its effect on valued interests’.<sup>89</sup> Culpability requires a fuller argument. Currently, the defendant’s state of mind is not necessarily relevant to a finding of gross negligence manslaughter,<sup>90</sup> the grossness of the negligence *per se* provides the necessary *mens rea*: In short, was the defendant’s conduct sufficiently bad to merit criminal sanction?

## Errors Versus Violations

Merry and Brookbanks state ‘morally relevant wrongdoing can only properly be identified if the actions of those whose responsibility is in question are subjected to analysis designed to identify states of mind that are truly culpable’.<sup>91</sup> They continue by giving a detailed analysis of unintentional medical deaths by synthesising the perspectives of an eminent legal mind and a doctor practising the most manslaughter prone speciality of them all, anaesthesia.<sup>92</sup> For Merry and Brookbanks, two broad groups of mistakes prevail; the ‘error’ and the ‘violation’. An error is the sort of mistake that could be made by anyone just by simply being a human rather than a machine. They define an error in colloquial terms as ‘when one tries to do the right thing but actually does the wrong thing’.<sup>93</sup> Scientific evidence suggests that many doctors will commit this type of error at some point in their working life and anecdotal evidence suggests that most anaesthetists will make this kind of mistake during their careers.<sup>94</sup> Errors are further subdivided but all are viewed as lacking any culpable elements with the exception of the ‘egregious error’ which equates to the ‘grossest ignorance’ described in *Williamson*.<sup>95</sup> This might relate to a culpable attitude, but a failure of regulation may also feature. In their view, with the exception of the said egregious error, errors cannot be culpable as they are actions which ‘do not represent an informed choice of the resulting harm’.<sup>96</sup> For Merry and Brookbanks, it is the ability or the unexercised capacity to do things differently that is a necessary ingredient for culpability and criminal sanction.<sup>97</sup>

88. A Ashworth, ‘Is the Criminal Law a Lost Cause’ (2000) 116 *LQR* 225–256, at 241.

89. *Ibid* at 240. As Tadros opines ‘bad outcomes need not reflect a high degree of culpability’ (see V Tadros ‘Fair Labelling and Social Solidarity’ in L Zedner and J Roberts (eds), *Principles and Values in Criminal Law and Criminal Justice: Essays in Honour of Andrew Ashworth* (OUP, Oxford 2012) at 67–80, at 70.

90. *AG Ref* (n 48).

91. Merry and Brookbanks (n 6) at 12.

92. *Ibid* at 16.

93. *Ibid* at 108. The authors continue and propose a more formal definition of an unintentional error as one which ‘involves the use of a flawed decision or plan to achieve an aim, or the failure to carry out a planned action as intended’ (at 109).

94. Jon Maskill’s own experience of himself and colleagues over the last 25 years of anaesthetic practice. See also A Merry and D Peck, ‘Anaesthetists, Errors in Drug Administration and the Law’ (1995) 108 *New Zealand Medical Journal* 185.

95. Merry and Brookbanks (n 6) at 138; *R v Williamson* [1807] NSWC 3 C and P 635.

96. Merry and Brookbanks (n 6) at 388.

97. *Bawa-Garba* (n 2). Dr Bawa-Garba had the choice not to work on the under-resourced ward and Dr Sullman had a choice not to perform a lumbar puncture. However, for a junior doctor to refuse work delegated to them by a consultant is highly unusual. Dr Sellu did have a choice to refer his patient earlier but did not. Dr Adomako did have a choice to properly monitor his patient with a degree of vigilance proportionate to the situation but did not. See also Hart (n 54).

‘Violations’ are defined as intentional deviations ‘from those practices deemed necessary . . . to maintain the safe operation of a potentially hazardous system’.<sup>98</sup> The doctor has made a decision ‘to do something in the knowledge that the given action or decision will place at risk some aspect of safety or of the system’.<sup>99</sup> Although acknowledging that not all violations will be equally culpable, Merry and Brookbanks contend that violations will always be blameworthy ‘because violations involve choice’.<sup>100</sup> However, an assessment of the clinician’s actions should not confuse what ‘*could reasonably* be expected to have been done’ with ‘what *ought* to have been done’.<sup>101</sup> A violation may indeed be reprehensible depending on the reason for it; a lazy shortcut or a well-reasoned aberration. However, the violation must be considered in the context of the prevailing circumstances the defendant was faced when it occurred.

### Can Negligence Be Culpable?

Negligence implies ignorance or inadvertence, and a negligent doctor should not be criminally liable for a momentary lapse of concentration or inadvertence; an error of judgment. However, the imposition of criminal liability may be apposite for a doctor who has a wilful disregard for the safety of others, a doctor guilty of a violation. But, if negligent conduct is culpable, and labelled a violation, three factors must be present.

#### (i) Awareness

The defendant must be aware that there is a risk if they omit to act or elect to act in a certain way. Horder contends that criminal liability may be justified if the defendant ‘acted in spite of the reasons against so acting where those reasons (objectively) outweighed the reasons in favour, and he knew or she knew or suspected that this was the case’.<sup>102</sup> For a finding of gross negligence manslaughter there must be ‘some conscious, occurrent awareness of a risk of harm to others, wilful blindness or cognitive dissonance in respect of such a risk’.<sup>103</sup> This concept must include the defendant who was wilfully ignorant of the risk; ignorance must not be exploited to excuse blame. This awareness is not necessarily tied to the time of the event; an accused may be aware of a threat before the incident, for example, at the ‘preparatory’ stage yet the defendant fails to take steps to minimise or avoid the risk by his subsequent actions.<sup>104</sup> A degree of awareness may also be present in a simple negligent action; such as the motorist who drives at an excessive speed in a built-up area or an employer who fails to provide safety helmets. All are aware that there are risks attached to their actions or inactions. Awareness of the risk is therefore only one factor.

#### (ii) Choice

The defendant must have exercised a conscious choice to act (or omit to act). The grossly negligent doctor, being aware of the danger, has weighed up the reasons for and against action.<sup>105</sup> Against the backdrop of the defendant’s recognition of the risks, the element of choice is key—blame should only

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98. Merry and Brookbanks (n 6) at 150 referring to J Reason, *Human Error* (CUP, New York 1990), 195.

99. *Ibid* at 150.

100. *Ibid* at 389.

101. *Ibid* at 389.

102. J Horder, ‘Gross Negligence and Criminal Culpability’ (1997) 47(4) *UTLJ* 495, 512.

103. Lodge (n 31), 134. Such behaviour is labelled reckless by Anne Lodge but we suggest more generally may be used to distinguish the criminal conduct from simple negligence.

104. For a doctor, this may include failing to keep up to date with important professional safety issues. Doctors receive important safety updates from their Royal College, GMC and public health bodies in addition to their employers’ mandatory training sessions.

105. Lodge (n 31), 135 refers to the ‘choice theory’ which proposes ‘blame is only justified if the agent could have chosen otherwise than he did’.

attach to the defendant's conduct if the defendant could have chosen to act differently and it is this ability to make a choice that distinguishes the criminally culpable doctor from the negligent doctor. The former being aware of the risk has consciously chosen to run, ignore, chance their luck, be indifferent to, act with a cavalier attitude, in essence *act illogically and reach a conclusion so unreasonable that no reasonable person could ever have come to it*.<sup>106</sup> Fatigue is cited as increasing the chances of both error and violation and the incidence of which is evident in many of the prosecuted manslaughter cases.<sup>107</sup> Merry and Brookbanks contend that accepting elective work while fatigued is a violation of a safe practice.<sup>108</sup> The doctor made the choice to run an unnecessary risk and has the capacity to refuse to work in contrast to the doctor in Accident & Emergency (A&E) who has a duty to treat all who come through the department's doors. It is acknowledged that often there are complex reasons involving issues of healthcare resources and organisation that may result in a doctor electing to commit occasional violations with the most laudable of aims. However, a doctor accepting elective work who willingly decides to run a risk in the face of an alternative course of action has committed a violation.

### (iii) Control

Husak writes that 'a state of affairs is under our control when we have the ability to alter it if given a reason to do so'.<sup>109</sup> For a doctor's actions to fall within the auspices of the criminal law that the doctor must have had the ability to alter the chain of events. So, for the fatigued A&E doctor referred to above, this element of control is absent. They may be aware of the risks of continuing to work, but they have no control over the lack of staff cover that necessitates that they must carry on. The circumstances faced by this doctor mean they are not to blame.

Taking these elements, awareness, choice and control, and additionally importing principles from public law, the next section outlines a new model for gross negligence manslaughter, which better defines the boundary between criminal negligence and tortious negligence. This sliding scale of negligence will delineate more clearly the defendant's wrongdoing and assessment of culpability.

## The Sliding Scale of Negligence

The courts have indicated that an analysis of the defendant's state of mind need not be a prerequisite for a conviction,<sup>110</sup> therefore the focus of the present test is principally on how far below a professional standard the defendant's conduct fell. If the conduct itself solely provides the necessary *mens rea* (as

106. *Lodge* (n 31), 141. *Lodge* contends that 'An inadvertent defendant, wholly unaware of the risk (even one that would be immediately apparent to a reasonable observer in circumstances where conduct-guiding rules are established) does not make such a choice and thus does not render themselves vulnerable to criminal conviction'. See *Bolitho v City of Hackney HA* [1997] 3 WLR 1151 and *Associated Provincial Picture Houses Ltd v Wednesbury Corporation* [1948] 1 KB 223 and '*Wednesbury* unreasonableness' discussed in the next section.

107. See Drew Dawson and Kathryn Reid 'Fatigue, Alcohol and Performance Impairment' (1997) 388 *Nature* 235. There are several examples of fatigue being a factor in cases of gross negligence. Mr Garg had been on duty for eight days *R v Garg* [2012] EWCA Crim 2520, [2013] 2 Cr App Rep (S) 203; Dr Adomako had a maximum of four hours sleep *Prentice; Adomako; Holloway* (n 17); Dr Urbani was said to have been 'exhausted' in 'CQC calls for closer scrutiny after out-of-hours GP kills patient', *Nursing Times* online (2nd October 2009) [www.nursingtimes.net/news/primary-care/cqc-calls-for-closer-scrutiny-after-out-of-hours-gp-kills-patient-02-10-2009](http://www.nursingtimes.net/news/primary-care/cqc-calls-for-closer-scrutiny-after-out-of-hours-gp-kills-patient-02-10-2009) (accessed 28 July 2020); and in Canada Dr Verbrugge was accused of actually being asleep 'Anesthesiologist Found Negligent in Boy's Death' *New York Times* (24 October 1996) <<http://www.nytimes.com/1996/10/24/us/anesthesiologist-found-negligent-in-boy-s-death.html>> accessed 10 June 2020.

108. Merry and Brookbanks (n 6) at 170.

109. D Husak, 'Negligence, Belief, Blame and Criminal Liability: The Special Case of Forgetting' (2011) 5 *Criminal Law and Philosophy* 199–218. See further L. Alexander, K Ferzan, and S Morse, *Crime and Culpability* (Cambridge, CUP 2009). In their discussion of if beliefs or desires are under our control they contend that 'one is not culpable for one's ignorance unless one is in control of it' at 77. Husak disagrees with this view and contends that if beliefs and desires are outside our control then 'it is hard to see how actions can be under our control' at 204.

110. *AG Ref* (n 48) at 809; *Misra* (n 28) paras 56,57.



suggested by Judge LJ in *Misra*),<sup>111</sup> then any newly advanced model must be capable of differentiating between actions that are merely negligent, from acts that might properly be labelled a violation. Consequently, as the emphasis is on the degree of negligence necessary to be considered criminally culpable, this new model is labelled the ‘sliding scale of negligence’.

The discussion begins at the start of the sliding scale with a critique of the tests used to establish civil liability before using as a backdrop the case of *Adomako* and the clinical negligence cases of *Barnett* and *Bolitho*,<sup>112</sup> advocating that civil and administrative law can be utilised in a new gross negligence manslaughter test. It is contended that when the end point of the sliding scale is reached and the defendant’s behaviour is illogical or egregious, negligence should be adjudged as gross and potentially culpable.

### The Starting Point—Simple Negligence and the Bolam Test

In civil and criminal law it is accepted that a doctor owes a duty of care to their patient and in both a criminal and clinical negligence claim the claimant must establish a breach of that duty. The standard of care in civil law in a clinical negligence case is governed by the *Bolam* test.<sup>113</sup> A doctor must attain

... the standard of the *ordinary* skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is well established law that it is sufficient if he exercises the *ordinary skill of an ordinary competent man* exercising that particular art. (per McNair J)<sup>114</sup>

The threshold for establishing clinical negligence is a difficult one for a claimant to prove, made even more so as there is likely to be more than one form of accepted practice. This point was explicitly recognised by McNair J, who stressed that the court should not find the defendant negligent simply on the basis there was ‘a body of opinion that takes the contrary view’.<sup>115</sup>

The *Bolam* test has been the subject of extensive criticism. It has been viewed as the epitome of self-regulation, at its worst regarded as allowing the negligent doctor to escape liability by simply calling on other doctors to endorse the lowest common denominator in clinical practice.<sup>116</sup> *Bolam* seemingly permitted the courts to adopt a descriptive approach to the expert evidence, if there were other doctors, that might have behaved as the defendant did, then the defendant will have acted with ordinary care and will not be in breach of duty. The role of the court became solely to determine the existence of an accepted practice that would endorse the defendant’s actions. If such a body of evidence existed, the defendant would not be negligent.<sup>117</sup> Norrie argued that what was required was a normative interpretation of *Bolam* and the expert evidence and that the courts should be seen to engage with the expert evidence.<sup>118</sup> A normative approach asks ‘is this what doctors *should* do’ specifically what *should* be done in the circumstances rather than ascertaining, is this what doctors *ordinarily* do. Norrie maintained

111. *Misra* (n 28) paras 56,57.

112. *Bolitho* (n 106); *Barnett v Chelsea & Kensington Hospital Management Committee* [1968] 2 WLR 422.

113. *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

114. *Ibid* at 586. The forerunner to the *Bolam* test was the Scottish case of *Hunter v Hanley* 1955 SLT 213, Lord President Clyde stating, ‘The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of, if acting with ordinary care’ at 217.

115. *Ibid*.

116. See K Norrie, ‘Medical Negligence: Who Sets the Standard?’ (1985) 11 *Journal of Medical Ethics* 135–37. Norrie contends that medical practice is aimed at treating the particular patient who has their own particular needs rather than simply providing treatment to that type of patient. He concludes that ‘Medical treatment is not determined by plebiscite: neither is its legal acceptability’ at 137.

117. Jose Miola, ‘*Bolam v Friern Hospital Management Committee*: Medical Law’s Accordion’ in J Herring and J Wall (eds), *Landmark Cases in Medical Law* (Bloomsbury Publishing, London 2015), 23. Cases such as *Whitehouse v Jordan* (n 39) and *Defreitas v O’Brien* (1995) 25 BMLR 51 are good illustrations of the court deferential approach to medical expert evidence.

118. K Norrie, ‘Common Practice and the Standard of Care in Medical Negligence’ (1985) *Juridical Review* 145.

that McNair's reference to the 'reasonable' doctor permitted the court to take into account all of the relevant facts and circumstances of the particular case.<sup>119</sup> However, the aftermath of *Bolam* was characterised by innate reluctance by the judiciary to question medical opinion.<sup>120</sup>

Falling short of the *Bolam* test rarely led to a finding of criminality, the negligent doctor who failed to comply with accepted practice was not usually the doctor who also exhibited such 'a gross dereliction of care'.<sup>121</sup> Negligence simply describes the harm resulting from a breach of duty with no element of culpability implied. The *Bolam* test is only the first point on the sliding scale of negligence.

### Logic and Lacunas—Moving Along the Scale

In the clinical negligence case *Bolitho v City of Hackney HA*, the defendant doctor negligently failed to attend Patrick Bolitho who subsequently suffered respiratory arrest and later died.<sup>122</sup> Commenting on the *Bolam* test and the use of expert evidence, Lord Browne-Wilkinson said the proposed medical opinion must have a logical basis and that,

... , the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter.<sup>123</sup>

Lord Browne-Wilkinson acknowledged that it would only be in a 'rare case' that the expert opinion would not be 'capable of withstanding logical analysis', and,

It is only where a judge can be satisfied that the body of expert opinion *cannot be logically supported at all* that such opinion will not provide the benchmark by reference to which the defendant's conduct falls to be assessed.<sup>124</sup>

Logic is regarded as a certain way of thinking, a deduction/inference, that is, if 'X then Y'. A logical decision is one that is reasonable and founded on good judgment. Whether an individual's reasoning is logical is not the same question as whether their decision was reasonable in all the circumstances, a value judgment. The majority of clinical negligence cases that reach the civil courts involve a normative appraisal of the evidence in which the courts decide if the approach adopted was 'reasonable in the circumstances', not if it was the only right answer. The use of logic in *Bolitho* was arguably the wrong call as what was required was a detailed analysis of the risks and benefits of intubating. Reading the judgment of Lord Browne-Wilkinson it is not evident in *Bolitho* that any such analysis occurred,

Intubation is not routine, risk-free process . . . it cannot be suggested that it was illogical for Dr Dinwiddie, a most distinguished expert, to favour running what, in his view, was a small risk of total respiratory collapse rather than submit [the child] to the invasive procedure of intubation.<sup>125</sup>

119. *Ibid* at 152 and Miola (n 117), 23. Arguably, McNair did not intend the judiciary to continually defer to accepted practice and had actually given the judiciary licence to prefer one body of medical evidence over another, 'it is not essential for you to decide which of the two practices is the better practice, as long as you accept that what . . . [the doctor] did was in accordance with a practice accepted by proper persons; but if the result of the evidence is that you are satisfied that this practice is better than the practice spoken of on the other side, then that is a stronger case' (*Bolam* (n 113) at 587).

120. See, eg, *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] 2 WLR 480 at 487 'The law imposes the duty of care: but the standard of care is a matter of medical judgment' (per Lord Scarman); *Maynard v West Midlands RHA* [1984] 1 WLR 634 at 639 'A court may prefer one body of opinion to the other: but that is no basis for a conclusion of negligence' (per Lord Scarman). *Whitehouse v Jordan* (n 39).

121. *Adomako* (n 10).

122. *Bolitho* (n 106). The defendant argued however that even if she had attended she would not have intubated Patrick and thus prevented his injuries. Ultimately, this argument was accepted and the claimant's case failed on causation.

123. *Ibid* at 1159.

124. *Ibid* at 1160.

125. *Ibid*.

Notwithstanding the questionable use of the term ‘logic’ *Bolitho* has been said to put a gloss<sup>126</sup> on the *Bolam* test, the medical practice that the defendant doctor relies on must not only be *Bolam* compatible but *Bolitho* compliant; it must be both reasonable and logical. Perhaps, as Lord Browne-Wilkinson stated, only in those very rare circumstances<sup>127</sup> where it is glaringly obvious that the defendant should have adopted another course of action that the courts will intervene but nonetheless the courts can and have intervened when the accepted practice is adjudged as logically indefensible.<sup>128</sup>

Could logic be utilised in a new test for gross negligence manslaughter? The majority of clinical negligence cases that are ‘logically indefensible’ are likely to be settled simply because the internal consistency of the expert evidence does not add up. However, is an illogical doctor, a doctor whose actions ‘cannot logically be supported at all’,<sup>129</sup> so far removed from the grossly negligent doctor? A grossly negligent doctor is considered to have behaved *illogically* where there has been blatant disregard for accepted practice or adherence to an outdated practice *and* they have failed to recognise the risks in their approach could cause the death of a patient.

Lodge writes that ‘in the criminal context negligence requires unreasonable risk-taking’.<sup>130</sup> Substitute ‘illogical’ for ‘unreasonable’; would that produce a test that avoids needing to determine the ‘grossness’ of the negligence?

In his analysis of a logical practice, Lord Browne-Wilkinson referred to the judgment of Sachs LJ in *Hucks v Cole* as being one of those rare cases where the accepted practice was illogical.

When the evidence shows that a lacuna in professional practice exists by which risks of grave danger are knowingly taken, then, however small the risk, the court must anxiously examine that lacuna . . . If the court finds . . . there is no proper basis for the lacuna, and that it is definitely not reasonable that those risks should have been taken, its function is to state that fact and where necessary to state that it constitutes negligence.<sup>131</sup>

In *Hucks*, the doctor failed to prescribe penicillin to a patient following childbirth resulting in her contracting puerperal fever. There was no logical explanation for not electing to prescribe a drug that was inexpensive, widely available and could minimise if not eliminate a known risk. A scenario where there is a known risk X therefore follow step Y to minimise that risk. In *Bolitho*, the courts in judging the defendant not negligent for failing to intubate seemed to set the bar very high for a finding of illogical conduct. Previously, in *Bolitho*, in the Court of Appeal, LJ Dillon referring to the judgment of Sachs LJ in *Hucks*, stated that the courts should only reject medical opinion,

if the court, fully conscious of its own lack of medical knowledge and clinical experience, was none the less clearly satisfied that the views of that group of doctors were *Wednesbury* unreasonable, *i.e.* views such as no reasonable body of doctors could have held.<sup>132</sup>

The concept of *Wednesbury* unreasonableness has its origins in administrative law.<sup>133</sup> In keeping with Teff,<sup>134</sup> the *Wednesbury* threshold is not an apposite test for a clinical negligence claim, but it may be part of the solution to the difficulties with the current test of gross negligence.

126. See M Brazier and J Miola, ‘Bye Bye Bolam: A Medical Litigation Revolution?’ (2000) 8 *Med L Rev* 85.

127. *Bolitho* (n 106) at 1160.

128. See, eg, *Marriott v West Midlands HA* [1999] Lloyd’s Rep Med 23; *Fallon v Wilson* [2010] EWHC 2978; *Pearce v United Bristol Healthcare NHST* (1998) 48 BMLR 118.

129. *Bolitho* (n 106) at 1160.

130. Lodge (n 31) at 128.

131. *Hucks v Cole* [1993] 4 Med LR 393 at 397.

132. *Bolitho v City of Hackney HA* [1993] 4 Med LR 381 at 392.

133. *Associated Provincial v Wednesbury* (n 106).

134. Teff, ‘The Standard of Care in Medical Negligence—Moving on From Bolam’ 18 *Oxf J Leg Stud* 473 at 480.

## Wednesbury—When No One Would Have Acted as the Defendant Did

One of the grounds for an application for judicial review is that the decision made by a public authority was irrational. In *Associated Provincial Picture Houses Ltd v Wednesbury Corporation*,<sup>135</sup> a decision was labelled irrational if '[i]t is so unreasonable that it might almost be described as being done in bad faith', and that to prove a decision as irrational 'would require something overwhelming'.<sup>136</sup> In such an instance, the court could legitimately interfere.

The concept of bad faith is more often associated with claims in contract and commercial dealings, although medical law has also recognised its usefulness in assessing the integrity of a doctor's decision.<sup>137</sup> A doctor who either intentionally or maliciously adopts a course of action resulting in the death of their patient has clearly acted in bad faith. Such a doctor is negligent, additionally culpable and therefore a criminal. Similarly, the doctor who knowingly disregards a risk and has embarked on a path that has no logical basis or explanation, or follows a course of action that 'no sensible person who has applied his mind to the question to be decided could have arrived at it'<sup>138</sup>; such a doctor's actions are illogical, grossly unreasonable and *potentially* criminal.

The *Wednesbury* test demands evidence that is overwhelming. Lord Diplock describes the court power to review a decision 'which is so outrageous in its defiance of logic or accepted moral standards' that it would be endorsed by no one.<sup>139</sup> A criticism of the *Wednesbury* test, as applied in an administrative law context, is that the evidential threshold is impossibly high. However, given the consequences of labelling a doctor a criminal, the *Wednesbury* test in a revised gross negligence manslaughter test could be apposite. This further notch along the sliding scale, (*Wednesbury*) unreasonableness may appease those who would contend a test based on logic is insufficiently rigorous.

The following paragraph reruns a variation of the facts of *Bolitho* to demonstrate how this new test might work in a case of gross negligence manslaughter.

### (i) *Bolitho* adjusted

Imagine the registrar (Dr Horn) attends Patrick Bolitho and is concerned that a third episode of life-threatening respiratory distress may occur imminently.<sup>140</sup> Instead of preparing for such an eventuality by calling the consultant, arranging for an urgent intensive care review and preparing drugs and equipment for immediate intubation, she simply goes back to clinic.

The doctor in this scenario is *aware* of the *risks of grave danger* but fails to make any attempt to avoid that risk, the risk is embraced, it is *knowingly taken*. The doctor's actions are illogical—in this situation, there can only be one answer—an x therefore y deduction. This doctor is operating in a lacuna, the doctor has *chosen* to *knowingly* take a risk which poses grave danger to the patient.<sup>141</sup> This is a violation, it is a deliberate choice to deviate from accepted practice.<sup>142</sup> A risk that can, and should, be easily avoided. The doctor has *control* over the situation, there are no extraneous factors preventing this doctor from electing

135. *Associated Provincial v Wednesbury* (n 106).

136. *Ibid.*, 229. The court observed that 'it may be still possible to say that, although the local authority have kept within the four corners of the matters which they ought to consider, they have nevertheless come to a conclusion so unreasonable that no reasonable authority could ever have come to it'.

137. Section 1(1) Abortion Act 1967 provides a statutory defence to the Offences Against the Persons Act 1861. Section 1(1) provides that a person shall not be guilty of an offence when a pregnancy is terminated by a registered practitioner if two medical practitioners are of the opinion, formed in good faith that one of the grounds under s 1(1) are met. In *R v Smith* [1974] 1 All ER 376, a doctor was found not to have acted in good faith as he failed to make any enquiries into the woman's circumstances or examine the patient.

138. *CCSU v Minister for Civil Service* [1985] AC 374 at 410.

139. *Ibid.*

140. *Bolitho* (n 106).

141. *Hucks* (n 131) at 1160.

142. Merry and Brookbanks (n 6) at 150.

to follow a different course of action. By returning to the clinic this doctor has reached a decision which is grossly unreasonable, a decision that no reasonable doctor would support ‘in all the circumstances’.<sup>143</sup> The doctor’s actions were so bad (substitute illogical or grossly unreasonable) as to justify the imposition of criminal liability. Our hypothetical doctor may be guilty of gross negligence manslaughter.

Ashworth previously suggested that tests founded in negligence may be appropriate in establishing criminal liability where the harm is great, the risk of it occurring is obvious and where the defendant has both the duty and the capacity to avoid the risk.<sup>144</sup> This is true, however, the doctor must be aware of the risk and have control over whether to make the obvious and logical choice to avoid that risk. In those circumstances, what might be deemed foolhardy, risky, dicey or whatever epithet favoured, is conduct that is not only illogical and unreasonable but may also be criminal. What those circumstances are is the focus of the next section, together with a further exploration of the illogical and unreasonableness test.

### ***Adomako and Bolitho Revisited and Introducing Barnett—The Grossly Illogical/Unreasonable Doctor in all the Circumstances***

The previous sections outlined the facts of *Adomako* and *Bolitho*. *Barnett*, however, is a new addition to the discussion. In *Barnett v Chelsea & Kensington Hospital Management Committee*,<sup>145</sup> three night-watchmen presented at a hospital casualty department complaining that they had been vomiting for three hours after drinking tea. The nurse on duty reported their complaints by telephone to the duty medical casualty officer, who, without seeing the men, instructed the nurse to inform the men to go home to bed and see their own doctor. Five hours later, the men were dead from arsenic poisoning, later sourced to their tea. A widow of one of the men unsuccessfully claimed that the casualty officer was negligent for failing to attend her husband.<sup>146</sup> Factually, *Barnett* and *Bolitho* are similar in that both doctors were negligent for failing to attend their respective patients. Similarly, *Adomako* negligently failed to monitor his patient. In all three cases, it is contended that the defendants’ breach of duty was illogical, grossly unreasonable and potentially causative of the death of their patient. *Barnett*, *Bolitho* and *Adomako* will now be used to illustrate the blurring of civil and criminal liability and the feasibility of a sliding scale approach to criminality. The framework proposed by Brazier and Alghrani proves helpful in this regard.<sup>147</sup>

*First, did the doctor owe a duty of care to the patient?*

As a starting point, a necessary element is establishing a duty of care. Dr *Adomako* owed such a duty, as did Dr Horn in *Bolitho* and the casualty officer in *Barnett*.

*Was the doctor in breach of that duty? Is there simple negligence?*

Yes, *Adomako* breached his duty of care, as did Dr Horn and the casualty officer in *Barnett*. All three doctors’ care fell below the *Bolam* standard, the first limb of the Brazier and Alghrani test.<sup>148</sup> In all three cases, there is simple negligence and a civil action.

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143. *Adomako* (n 10), 187.

144. Ashworth (n 33) 187–88.

145. *Barnett* (n 112).

146. The claim ultimately failed on causation. The evidence indicated that the poisoning was too far advanced for any intervention to have saved the claimant’s life.

147. Brazier and Alghrani (n 57) at 65.

148. *Ibid.*

*Should the breach be categorised as gross negligence?*

Brazier and Alghrani categorise a doctor's actions as gross if that doctor has showed an indifference to an obvious risk of serious injury to the patient.<sup>149</sup> Substituting illogicality for indifference may produce a clearer outcome. Adomako was *aware* that the patient was paralysed and totally dependent on the ventilator but illogically failed to monitor whether the ventilator was connected to his patient. Being *aware* of the risk, making a *choice* (in his case to do nothing) and having *control* over the situation, Dr Adomako's actions were both (*Bolitho*) illogical and (*Wednesbury*) unreasonable. It was a decision that 'no sensible person . . . could have arrived at'.<sup>150</sup> Similarly, the non-attendance by the casualty officer in *Barnett* demonstrates an indifference that was illogical. A doctor failing to attend a patient and wilfully ignoring symptoms is *aware* of the risk of serious injury and having a *choice* to act otherwise has failed in their duty to safeguard their patient.<sup>151</sup>

In *Bolitho*, the failure of Dr Horn, the Senior Paediatric Registrar, to attend Patrick Bolitho on not just one but on two occasions was negligent. Being *aware* of Patrick's medical history of a heart condition and croup, and that Patrick 'was having difficulty in breathing and was very white',<sup>152</sup> Dr Horn *chose* not to attend. However, does this mean that any failure to attend a patient is negligent with the potential for criminal liability? In *Bolitho*, Dr Horn delegated this duty to Dr Rodgers. Disastrously, she too failed to appear, contending that she failed to receive any instruction. Although Dr Rodgers may have been negligent for failing to attend Patrick Bolitho, she was unaware of the impending crisis, she was unaware of the risks of non-attendance, there was no choice made to disregard the risk, she was not in control of the situation and consequently Dr Rodgers cannot be criminally liable. Returning to the words of Lord Mackay in *Adomako*, any non-attendance must be viewed in the context of 'all the circumstances', on the spectrum of inadvertence and only if the obligatory ingredient of culpability is evident will negligence stray into the domain of the criminal law.<sup>153</sup>

*The doctor who was aware and the doctor who should have been aware. Illogicality/unreasonableness a catch all proviso?*

Brazier and Alghrani distinguish between the doctor who is aware of the risk and opts to disregard it and the doctor who is unaware but should have been aware if they had been complying with accepted practice. This is not always an exculpatory distinction. If the doctor is aware and elects to unnecessarily run that risk, then their actions are illogical and potentially *Wednesbury* unreasonable. Similarly, if the doctor is unaware but deliberately deviates from accepted practice, then their actions are also illogical. Conceivably, Adomako could have argued that he was unaware of the risk but the fact that he chose not to monitor the patient-ventilator connection (contrary to standard practice) and then failed to recognise the disconnection were choices that an anaesthetist following accepted practice and acting logically would have avoided.<sup>154</sup> In *Barnett*, the medical expert commenting on the duty of the casualty officer said,

149. *Ibid.*

150. *CCSU v Minister for Civil Service* (n 138).

151. Brazier and Alghrani (n 57), 65. As Brazier and Alghrani remark, the doctor being aware of a risk has 'exposed the patient to that risk for no accepted medical benefit'.

152. *Bolitho* (n 106) at 1153.

153. *Adomako* (n 10), 187. Brazier and Alghrani (n 57) refer to mitigating circumstances. *Bolitho* (n 106), 1154 produced two incidences of negligence. The court were invited to speculate on what steps Dr Horn would have then taken had she attended and whether it would have been negligent to run the risk of total respiratory collapse rather than intubate. Expert evidence was equivocal and consequently the court were obliged, as the *Bolam* test dictates, to find that she would not have been negligent for failing to intubate. For the reasons outlined earlier, with respect this is incorrect. Logic decrees that this was an episode of 'unreasonable risk-taking'. Whether this conduct was also blameworthy is decidedly more awkward.

154. *Prentice; Adomako; Holloway* (n 17).

‘In my view, the duty of a casualty officer is in general to see and examine all patients who come to the casualty department of the hospital’ . . . ‘When a nurse is told that three men have been vomiting having drunk tea and have abdominal pains her duty is to report it, and she should report accurately to the doctor. The first step she should take to deal with the matter is to take a history’ . . . ‘I cannot conceive that after a history of vomiting for three hours a doctor would leave the matter to a nurse, however experienced the nurse’.<sup>155</sup>

Agreeing with these sentiments, Nield J commented, ‘[w]ithout doubt the casualty officer should have seen and examined the deceased. His failure to do either cannot be described as an excusable error as has been submitted. It was negligence’.<sup>156</sup>

The casualty doctor’s non-attendance was negligent, illogical and *Wednesbury* unreasonable. Ignorance should not be a defence for the blameworthy doctor unless such ignorance is both logical and defensible.<sup>157</sup>

*When two become one—Simple, gross and all the circumstances*

Accepting that all three of our defendants’ actions are illogical or grossly unreasonable, the final issue to address is where on the spectrum of negligence should such conduct attract criminal liability. Brazier and Alghrani contend negligence may be gross negligence unless there are mitigating circumstances.<sup>158</sup> In other words, the ‘all the circumstances’ caveat espoused by Lord Mackay in *Adomako*.<sup>159</sup> A test of illogicality or *Wednesbury* unreasonableness would cater for a consideration of extraneous factors. The fact that Dr Adomako had failed to keep up to date with areas of his practice would not lessen a finding of gross negligence, this would not excuse but corroborate a finding of his illogical conduct, Adomako’s conduct was by all accounts bad and deserving of criminal retribution.<sup>160</sup> Dr Horn in *Bolitho* and the non-attending casualty officer in *Barnett* also would have the opportunity to present an argument as to why their actions were not culpable given the circumstances they faced. A test of logic is to infer ‘if X then Y’, but if there is reason why Y is not the obvious solution, then those reasons must and should be accepted. Adopting a test of illogicality or unreasonableness does not preclude a fair hearing.<sup>161</sup> Competing demands on the defendant or even a failure of hospital equipment as was alleged in *Bolitho* may result in what appears to be an illogical course of action being pronounced sub-standard but not criminal.<sup>162</sup>

155. *Barnett* (n 112) at 428.

156. *Ibid.*

157. See Laird (n 39).

158. Brazier and Alghrani (n 57) at 65. They give the example of a doctor working in ‘circumstances that substantially impaired his ability to provide adequate care for his patient’ or a doctor who is allegedly unaware of a risk, a doctor who ‘lacked the experience or capacity to deliver the treatment in question’.

159. *Adomako* (n 10), 187.

160. In *Rowley v DPP* [2003] EWHC 693 (Admin), Lord Justice Kennedy analysing the four objective tests in *Adomako* said, ‘It is clear from what Lord Mackay said that there is a fifth ingredient: “criminality” (albeit defining the ingredient in this way “involves an element of circularity”) or “badness.” Using the word “badness,” the jury must be sure that the defendant’s conduct was so bad as in all the circumstances to amount “to a criminal act or omission.” Lord Hewart C.J. in *Bateman* used the words: “to amount to a crime against the state and conduct deserving punishment,” that is, conduct which does not merely call for compensation but for criminal punishment’ (para 28). This fifth ingredient of ‘badness’ does not feature in subsequent cases (see, eg, *R v Becker* [2000] WL 877688.)

161. This approach might be considered analogous to the civil law principle of invoking *res ipsa loquitur* (the thing speaks for itself). In the event of an accident which would not normally occur if proper care is taken and the defendant was in complete control of the event then the accident itself is evidence of negligence. The defendant will be held liable unless they can provide an explanation for the illogicality of the act or omission, see *Scott v London and St Katherine Docks Co* (1865) 3 H & C 596, [601] Erle CJ, *Cassidy v Ministry of Health* [1951] 2 KB 343. Note to rebut the inference of negligence the defendant’s explanation must be plausible, see *Saunders v Leeds Western HA* (1993) 4 Med LR 355.

162. *Bolitho* (n 106), 1154. The circumstances that doctors Prentice and Sullman and Bawa-Garba encountered lead to a very different conclusion as to the logicity and culpability of their conduct. Dr Prentice was the equivalent of an FY1 doctor and

A test of illogicality/*Wednesbury* unreasonableness removes the circularity of the present test for gross negligence manslaughter. A sliding scale from simple to illogical/*Wednesbury* unreasonable is a linear approach with clearer boundaries. Only when the illogical/*Wednesbury* unreasonable marker is met, is culpability considered. The illogical test is an objective test focused on an assessment of risks. The *Wednesbury* unreasonable test is even more clear-cut, the offender's actions are endorsed by no one. Applying such a test followed by an evaluation of the degree of blame would result in the acquittal of Prentice and Sullman and, probably, Dr Bawa-Garba but the conviction of Dr Adomako.

The preceding paragraphs explored what conduct should warrant the imposition of criminal liability and advocated a new approach. Accepting that the criminal law has a role to play in the regulation of the medical profession, is there a case for widening the scope of liability to include those actions causing harm falling short of death?

### Moral Luck—Should the Outcome Matter More Than the Violation?

Hubbeling concludes that 'when assigning blame and considering criminal prosecution and professional disbarment, one has to look at the actual behaviour and not at the consequences'.<sup>163</sup> He contends that 'blame should only be attributed if the behaviour was unusual and would not have been acceptable even without the adverse outcome'.<sup>164</sup> For Hubbeling, an adverse outcome leads to a duty to make amends but not blame.<sup>165</sup> The case of *Prentice and Sullman*, referred to by Hubbeling, is perhaps the best embodiment of the moral luck conundrum. A mistake resulting from systems failure led to the prosecution of two junior doctors. No blame was ascribed to the defendants, they were guilty of an error but not a violation, but because the doctors' error resulted in the death of a patient, this led to a criminal prosecution.<sup>166</sup> Herein lies the problem, Drs Prentice and Sullman were unlucky, death resulted from an excusable error. How, therefore, should the law respond where there is a violation that causes severe harm but does not end in death?

'Medical negligence only becomes a crime if the patient dies'.<sup>167</sup> This statement leads Griffiths and Sanders to, as they themselves acknowledge, surprisingly advocate an increase in scope of gross negligence manslaughter, to both recognise public concern and 'punish behaviour that in other contexts would be likely to be punished'.<sup>168</sup> They argue for 'a context-specific negligence-based offence for healthcare', which they contend would 'offer a fairer and more nuanced approach to using criminal law'.<sup>169</sup> Academics such as Quick have shied away from this idea, contending that medical errors are more variable than, say, driving offences and prosecutors would encounter difficulties in identifying the classification of the medical error.<sup>170</sup> It is true the present legal test is formulated in such a fashion that defining when negligence becomes criminal negligence is at best problematic, at its worst unfair. However, part of the problem, as Quick himself admits, is that the absence of a lesser crime means that gross negligence manslaughter is an 'all or nothing scenario'.<sup>171</sup> The Criminal Justice and Courts Act 2015, described below, may offer the broadening of scope suggested.

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had never administered the chemotherapy drugs or received the relevant training, Dr Sullman also had limited experience. Dr Bawa-Garba was working her first and very long shift after her return from maternity leave, she had little support from the consultant or nurses and encountered computer failures.

163. D Hubbeling, 'Medical Error and Moral Luck' (2016) 28 *HEC Forum* 229–43, at 241.

164. *Ibid.*

165. *Ibid.*

166. Given the leniency of sanction imposed by the GMC it is apparent that their profession was uncomfortable with their conduct being classed as criminal purely on the basis that a patient died.

167. D Griffiths and A Sanders, 'The Road to the Dock: Prosecution Decision-Making in Medical Manslaughter Cases' in Griffiths and Sanders (n 83) 117–58, at 126. See also Brazier and Alghrani (n 57).

168. Griffiths and Sanders (n 83) at 146.

169. *Ibid.* at 150.

170. Quick, 'Medicine, Mistakes and Manslaughter' (n 8), 198.

171. Quick, 'Prosecuting "Gross" Medical Negligence' (n 8), 424.



If a doctor's conduct were to expose a callous indifference to his patient but that patient suffered harm short of death, the doctor would ordinarily escape criminal sanction. The harmed patient is required to provide a lower standard of proof than in a criminal court in order to be compensated for the harm he has suffered. The criminal court represents the Crown, not the victim. Hence, in the field of medicine, injuries sustained through negligence, which would ordinarily meet the threshold for grievous bodily harm,<sup>172</sup> seldom result in the prosecution and conviction of the responsible doctor.

The National Advisory Group on the Safety of Patients in England was established to support the work of Robert Francis' review into the failures at Mid Staffordshire Hospital.<sup>173</sup> One of their conclusions was that there needed to be a process to deal with cases where the act or omission of a care worker constituted ill-treatment or wilful neglect. There already exists criminal offences to punish those who ill-treat or wilfully neglect children,<sup>174</sup> adults who lack capacity<sup>175</sup> or those subject to the Mental Health Act 1983, but until 2015 no offence to punish those who ill-treat or wilfully neglect adults with full mental capacity.<sup>176</sup>

To give effect to the recommendations made by the Francis review, the Criminal Justice and Courts Act 2015 contains the necessary legislation against ill-treatment and wilful neglect of adults with capacity.<sup>177</sup> Hence, the ill-treatment or wilful neglect of all persons is now covered, at least once, by statute.

On the face of it, these provisions appear to increase the scope of criminal liability for doctors. The offences of wilful neglect and ill-treatment are in *addition* to the common law offence of gross negligence manslaughter. Debate in the *British Medical Journal* sheds light on the disquiet this causes among doctors.<sup>178</sup> However, the offences accord with the proposition that it is the conduct of the doctor, rooted in the traditional *mens rea* and *actus rea* limbs of criminality, which gives the 2015 Act its appeal. Additionally, part of the Act deals specifically with the employers of those guilty of wilful neglect or ill-treatment.<sup>179</sup> The Corporate Manslaughter and Corporate Homicide Act 2007 need not be separately engaged.<sup>180</sup>

Common to all of the statutes criminalising wilful neglect is the definition of 'wilful'. This *mens rea* component requires a subjective awareness of the risk of harm.<sup>181</sup> It is a crime of omission. The omission itself need not actually cause harm; in this sense, it is *purely* a conduct crime with no outcome required.<sup>182</sup> However, from a practical perspective, it is hard to envisage how a doctor showing wilful neglect, which causes no harm, would fall under the gaze of a criminal court. The GMC is much more

172. Offences Against the Person Act 1861 (n. 49).

173. Francis Review <[www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry](http://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry)> accessed 24 December 2019.

174. Section 1 Children and Young Persons Act 1933.

175. Section 44 Mental Capacity Act 2005.

176. Karl Laird 'Filling a Lacuna: The Care Worker and Care Provider Offences in the Criminal Justice and Courts Act 2015' (2016) 37 Stat LR 1.

177. Sections 20–25 Criminal Justice and Courts Act 2015.

178. Pallavi Bradshaw 'Criminal offence of wilful neglect may undermine, rather than improve, patient safety' (2015) *British Medical Journal* <[www.jstor.org/stable/10.2307/26520660](http://www.jstor.org/stable/10.2307/26520660)> accessed 28th July 2020 and Jo Bibby and Christine Tomkins, 'Would Criminalising Healthcare Professionals for Wilful Neglect Improve Patient Care?' (2014) *British Medical Journal* <[www.bmj.com/content/348/bmj.g133](http://www.bmj.com/content/348/bmj.g133)> (accessed 28 July 2020).

179. Section 21 Criminal Justice and Courts Act 2015.

180. The Health and Social Care Act 2015 specifies punishment for neglect; a conduct offence. The Corporate Manslaughter and Corporate Homicide Act 2007 requires an outcome of death before being invoked. The 2015 Act alone could, conceivably, be invoked if neglect has resulted in death.

181. 'The Mental Element in Crime Part II. Specific Requirements as to State of Mind Section F. Wilfulness' in Mark Lucraft QC '*Archbold: Criminal Pleading, Evidence and Practice*' (Sweet and Maxwell, 2019); *R v Sheppard* [1981] AC 394 HL; *R v G* [2003] UKHL 50, [2004] AC 1034; *Turbill and Broadway* [2013] EWCA Crim 1422, [2014] 1 Cr App R 7; *AG Ref (No 3 of 2003)* [2004] EWCA Crim 868, [2004] 2 Cr App R 23.

182. *R v Patel* [2013] EWCA Crim 965, 2013 WL 2628767 [24].

likely to be notified of harmless wilful neglect (and act on it) than the police.<sup>183</sup> This would result in professional sanction.

Ill-treatment is easy to spot but more difficult to define. In *Heaney*, a nurse slapped one patient and put copious amounts of vinegar and sugar in another's tea.<sup>184</sup> Neither victim appeared distressed by the abuse, but the defendant was nevertheless given a custodial sentence. Again, it was the conduct which attracted criminal attention, not the outcome.

Both charges of wilful neglect and ill-treatment are capable of deterring bad behaviours which may lead to harm. If properly employed, along with the organisational sanctions included in the 2015 Act (in addition to existing Health and Safety law), violations can be deterred. Unfortunately, the Act is unlikely to make any impact on inadvertent errors, even those resulting in death. There still remains the problem of managing non-wilful neglect and unintended ill-treatment which cause death. The only criminal sanction is that of gross negligence which, as already argued, is not a suitable vehicle for deterrence or improving standards.

## Sentencing—The Final Bastion

Thus far, it has been argued that there needs to be a reformulation of the legal test of gross negligence manslaughter. Recent changes to the process of bringing a prosecution case, while welcome, do not address the faulty essence of the offence.<sup>185</sup> Vaughan *et al.*, however, believe the recent sentencing guidelines for manslaughter show a constructive approach at the end of the legal process.<sup>186</sup> Evidently, once the court is at the stage of sentencing, there is no going back; the doctor has been labelled a criminal with all the ensuing consequences. As Chalmers and Leverick note, a sentence may not reflect the degree of culpability as the sentence may be aggravated or mitigated because of unrelated factors to the offence.<sup>187</sup> However, the new sentencing guidelines do bring some shade and depth into what conduct is deserving of the harshest sanction.<sup>188</sup>

### The Guidelines

The guidelines came into force on 1 November 2018 and apply retrospectively. As Fidderman notes, this is the first occasion that the Council has issued a detailed guideline for manslaughter committed by an individual.<sup>189</sup>

To begin, the Council has included a general statement in relation to culpability, '[t]he court should avoid an overly mechanistic application of these factors'.<sup>190</sup>

Sensibly, this caveat echoes the Lord Mackay approach espoused in *Adomako* of reflecting on 'all the circumstances' of the offence.<sup>191</sup> The overall intent of the guidelines to embrace flexibility is to be welcomed.

183. General Medical Council '*Good Medical Practice*' devotes several sections to 'maintaining trust' and 'acting with honesty and integrity'; standards which must be demonstrated in formal annual appraisals, breaches of which must be reported to the GMC.

184. *R v Heaney* [2011] EWCA Crim 2682, [2011] 11 WLUK 155.

185. *Gross Negligence Manslaughter in Healthcare. The Report of a Rapid Policy Review* (June 2018) ('the Williams Review') at para 3.1. *Independent Review of Gross Negligence Manslaughter and Culpable Homicide* (June 2019) ('the Hamilton Review').

186. Vaughan, Quick and Griffiths (n 4), 254.

187. J Chalmers and F Leverick 'Fair Labelling in Criminal Law' 71 *Med L Rev* 217 at 218. See also *Adomako* (n 10) and the concept of 'moral luck' discussed above.

188. Manslaughter Definitive Guideline <[www.sentencing.council.org.uk](http://www.sentencing.council.org.uk)> accessed 15 June 2020.

189. H. Fidderman *H. & S. B.* 2018, 472, 6-8, A New Sentencing Guideline for Gross Negligence Manslaughter.

190. Sentencing Guidelines (n 188), 10.

191. *Adomako* (n 10).

The penalty range runs from 1 year to 18 years and as Wasik observes ‘reflect the wide, factual circumstances and range of culpability which can apply in an offence based on a breach of a standard of care rather than on traditional *mens rea*’.<sup>192</sup> There are four categories of culpability and one level of harm. At the most serious end of the spectrum, ‘the offender showed a blatant disregard for a very high risk of death resulting from the negligent conduct’.<sup>193</sup> This spectrum embraces factors indicating a lower level of culpability which include the offender’s actions identified as a ‘lapse’ in ‘otherwise satisfactory standard of care’ and the offender being in a ‘lesser or subordinate role if acting with others in the offending’.<sup>194</sup> The increased flexibility in approach to sentencing is further illustrated by the addition of new factors reducing the seriousness of the offence or alternatively being considered as mitigating circumstances. Although not healthcare-specific, the inclusion of new factors is a direct consequence of meetings between the Council and medical professionals. Factors ‘beyond the offender’s control’ may be pleaded in mitigation. These include:

- (i) the offender lacked the necessary expertise, equipment, support or training which contributed to the negligent conduct;
- (ii) the offender was subject to stress or pressure (including from competing or complex demands) which related to and contributed to the negligent conduct;
- (iii) the negligent conduct occurred in circumstances where there was reduced scope for exercising usual care and competence; and
- (iv) the negligent conduct was compounded by the actions or omissions of others.<sup>195</sup>

Plainly, the courts are keen to move away from the punitive approach adopted in *R v Garg*<sup>196</sup> and eager to utilise a greater variation in sentencing.

### ***Solution or Stop-Gap? Sentencing, Gross Negligence Manslaughter and the Sliding Scale***

The guidelines seem to have gone some way to addressing the criticisms of Quirk who argued that the sentencing framework should reflect the ‘spectrum of culpability and the particular circumstances in which doctors’ work’.<sup>197</sup> The approach taken in the revised sentencing guidelines effectively mirrors the ‘sliding scale’ of negligence; it acknowledges, expressly, that the defendant’s culpability is heavily influenced by all the circumstances surrounding the offence. Implicitly, the guidelines revisit *mens rea* as a necessary ingredient for the offence. Judge LJ previously stated that the grossness of the negligence provides the necessary *mens rea* for the offence and in *Attorney-General Ref (No 2)* the court stated that the defendant’s state of mind need not be a consideration.<sup>198</sup> The Sentencing Council have, perhaps, tacitly disregarded this approach. The most serious level of culpability echoes the proposed spectrum of negligence this would catch the doctor who carried on regardless, the clinician who ignored the red flag irrespective of the consequence, had no excuse and displayed a high level of culpability. This is recklessness, which has never been doubted as a highly culpable state of mind. The detailed examination of culpability in the sentencing guidelines ought, however, to also be evident at the prosecution stage.

192. Martin Wasik, ‘Reflections on the Manslaughter Sentencing Guidelines’ (2019) 4 *Crim LR* 315–332.

193. Sentencing Guidelines (n 188), 10.

194. *Ibid.*

195. *Ibid.* at 13.

196. *R v Garg (Sudhanshu)* [2012] EWCA Crim 2520.

197. H Quirk ‘Sentencing White Coat Crime: The Need for Guidance in Medical Manslaughter Cases’ (2013) 11 *Crim LR* 871–88 at 881.

198. *AG Ref* (n 48), *Misra* (n 28).

The addition of new mitigating factors also partially addresses the criticisms made by Dyer in relation to *R v Sullman and Prentice* who observed,

Bringing the full weight of the criminal law to bear on two fledgling doctors will do little to remedy a system which lets juniors loose on patients with too little training, too little support, and too little sleep.<sup>199</sup>

Recognition in the guidelines that clinicians work often in highly stressed and under-resourced environments is long overdue and a necessary and timely intervention. Yet the addition of these new mitigating factors is necessary only as a result of the failure of the present legal test to acknowledge ‘all the circumstances’ of the crime. Patently, if the legal test is reformed in the guise of the spectrum of negligence, the overworked, understaffed, ill-trained clinician would be unlikely to fall within the remit of the criminal law because of the absence of the apposite level of culpability. However, acknowledging that a reformed legal test is some way off, in the interim the guidelines have taken a positive step and have coherently mapped out the scale of culpability.<sup>200</sup>

It is disappointing, however, that the guidelines apply only to ‘harm of the utmost seriousness’ defined as the loss of life.<sup>201</sup> It is long overdue that the moral luck loophole is firmly closed, and the degree of negligence and blame should be the decisive factors in determining the level of criminality. The importance of the consequences of the clinician’s conduct is undiminished by accepting that the degree of blame is of greater significance to the level of criminality. Quirk commented on the previous sentencing regime, ‘the court has focused too much on the harm rather than the culpability’.<sup>202</sup> The new guidelines have partially redressed that inequality but to achieve a full equilibrium conduct resulting in serious harm should be accommodated.

## Conclusions: Criminal or Negligent—What Now for the ‘Bad’ Doctor?

There are many consequences from criminalising a negligent doctor. A negligent doctor may face professional disciplinary proceedings, limits imposed on their ability to practice, a cessation of any hope of professional advancement and crucially a *professional* reputation that is irreparably tarnished. Classifying negligent conduct as criminal, however, threatens a doctor with a *personal* reputation that is irreparably tarnished. The possibility of imprisonment will convey ‘the impression that his conduct was graver than it was’, and ‘the public may tend to shun the defendant on inadequate grounds, he may find it more difficult to find employment as a result’.<sup>203</sup> Doctors do not like going to court, Coroner’s, High Court or Crown, but as Brazier asserts ‘a civil claim does not mean professional ruin or personal disgrace’.<sup>204</sup>

There may be ‘nothing so concrete as a formula for defining what conduct should be criminalised’ but given that the stakes could not be higher whatever label the law applies to an offence ought fairly to represent the offender’s wrongdoing.<sup>205</sup> The present regime leaves little room for evaluation of the

199. C Dyer ‘Manslaughter Convictions for Making Mistakes’ (1991) 303 *British Medical Journal* 1218. Likewise, Dr Hadiza Bawa-Garba may have invoked not one but all of the mitigating factors in her defence.

200. The Council have stated that the aim is to achieve greater consistency in manslaughter sentencing although it does not expect sentence levels to change. The guideline allows for a suspended sentence of 1 year all the way to 18 years of custody. Few other offences exhibit such a range of punishment with a single act: causing the death of another human being. This may suggest that gross negligence manslaughter covers such a broad range of circumstances with just a single end point (death) and may not be used against both the wantonly reckless and the unlucky incompetent.

201. Sentencing Guidelines (n 188).

202. Quirk (n 197) at 888.

203. Tadros (n 89) 67–80, at 71.

204. Brazier and Alghrani (n 57) at 55.

205. Ashworth (n 88), 226.

doctor's actions. Lord Mackay in *Adomako* pointedly made reference to the need for a consideration of 'all the circumstances' and yet such has been the preoccupation with when simple negligence becomes gross, an assessment of whether the doctor is wholly culpable has not been given the necessary attention it demands and deserves.<sup>206</sup>

It is argued that the present test is broken, it lacks certainty and fails to identify what degree of fault is required for criminal censure. An alternative test is required. The 'major departure' test avoids the need to determine the 'grossness' of the negligence with a focus on accepted practice but arguably this too suffers from a lack of clarity. Given the very few criminal prosecutions in New Zealand and the shift of focus to improving patient safety, the test conceivably has a very limited role in the regulation of doctors. There is much to commend the Scottish regime, which puts culpability centre stage and additionally requires any prosecution to be in the public interest.<sup>207</sup> However, the Scots use the high bar of recklessness as the starting point for culpability. For too long the English courts have determined guilt or innocence solely on the basis of proof that the conduct in question fell below an objectively set standard without a satisfactory analysis of the subjective *mens rea* elements of the offence.

The sliding scale of negligence may be considered too formulaic but accepting that both criminal and civil liability share a common purpose to regulate sub-standard care; it is suggested this test can assess how bad the negligence is, to differentiate the simple from gross. Terms such as 'illogical' and 'a decision that would be endorsed by no one' are expressions that provide the jury with some form of benchmark rather than be reliant on their own individual perception of what they perceive as gross negligence. Mindful that for any criminal sanction, there must have been the ability or the unexercised capacity to have done things differently, reaching the end point of the sliding scale of negligence must then trigger an assessment of blame. Criminality requires culpability. If the doctor's actions are lacking in logic or would be endorsed by no one *and* the blame lies solely at the feet of this doctor, then this is a negligent *and* criminal doctor. The new sentencing guidelines are to be welcomed for clearly delineating the scale of culpability but by this stage the damage is done, the doctor is branded a criminal. The nuanced approach in sentencing must be reflected in the test itself, for once in the dock the horse has long since bolted.

Consideration should be also be given to broadening the offence to include instances of severe harm caused by gross negligence. Alternatively, greater use of the conduct-based criminal offences of wilful neglect and ill-treatment should be made to capture culpable gross negligence which causes harm short of death; luck should not be the determining factor in relation to criminality. Culpable conduct causing permanent harm is no less reprehensible than a conscious disregard resulting in a fatality and a system where it is 'the chance of death alone that transforms negligence from a civil to a criminal matter is illogical, regardless of whom the defendant might be'.<sup>208</sup>

As a final thought, the ongoing coronavirus pandemic raises more questions about the current legal test for gross negligence manslaughter. With intensive care resources stretched by demand, doctors are faced with deciding which patients should be given invasive ventilation. Two issues arise: the '*Bolam* standard of care' and 'all the circumstances'. In a negligence claim, determining whether a doctor's actions have fallen below the *Bolam* standard will be effectively decided by expert witnesses who may never have been directly involved in the pandemic. These same experts will be tasked with examining if the breach of duty is so serious as to be considered criminal. Whether the present circumstances are deemed exculpatory will inevitably depend on the personal experiences of the jurors, many of whom will have known people who have died from the virus. This makes for a very uncertain outcome. It is hoped that the Crown Prosecution Service, with its public interest test, will demand obvious 'badness' before

206. *Adomako* (n 10). 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.

207. Public interest is the focus of another article in this volume but culpability is pivotal if the doctor's conduct has reached the end point of the sliding scale.

208. Brazier and Alghrani (n 57) 66.

hauling mentally and physically exhausted intensive care staff into the criminal court. Culpability is key, for once in court their fate is entirely unpredictable.<sup>209</sup>

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209. In the words of Freckleton (n 34), 'We must be realistic and not aspire unreasonably to perfection in clinical practice, especially in such working conditions'. See further Jon Maskill and Michelle Robson "Covid-19-Legal Issues—A Response to the BMA" <[www.researchgate.net/publication/340563156](http://www.researchgate.net/publication/340563156)> accessed 15 June 2020.