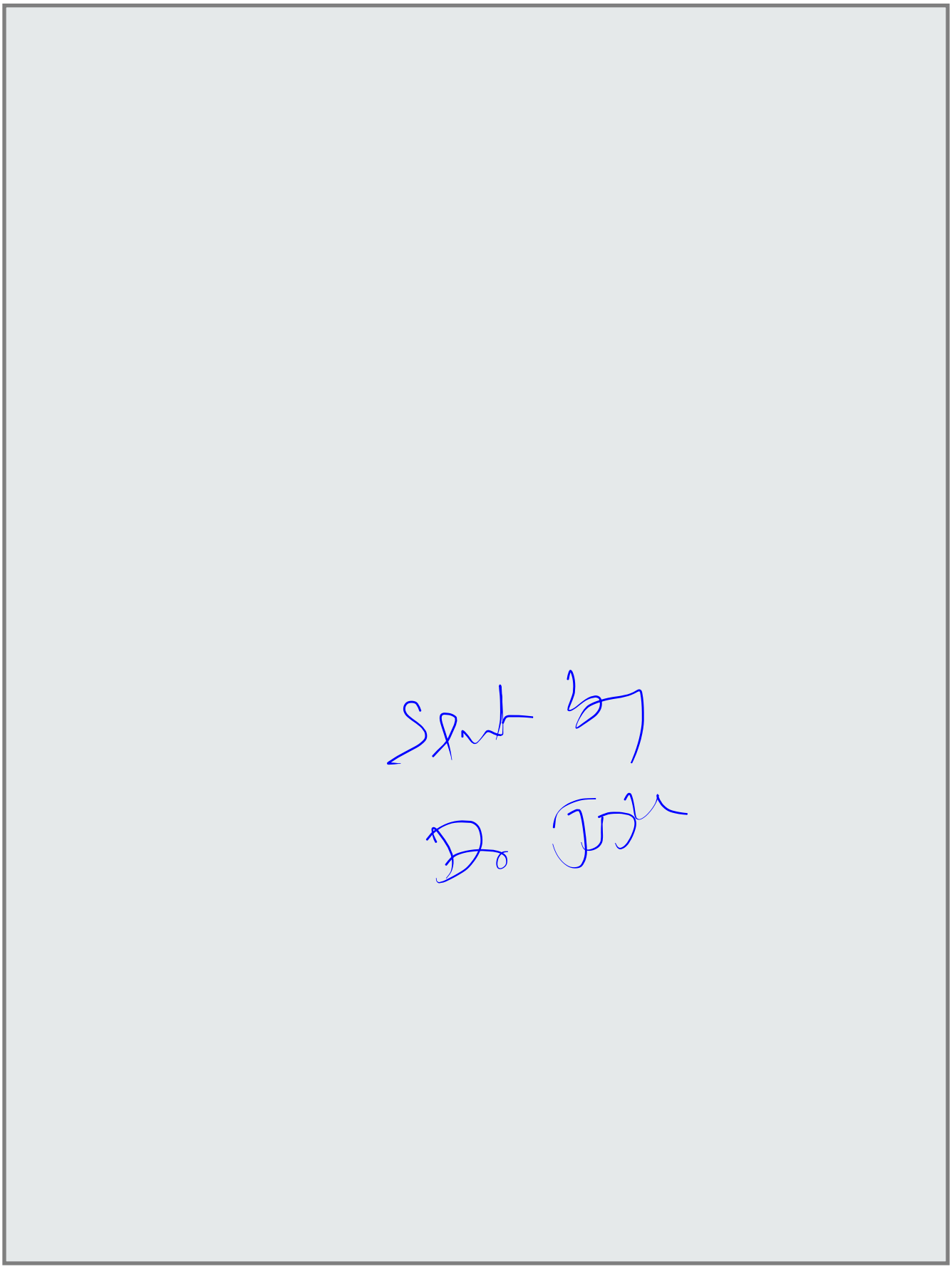
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BEFORE THE HONOURABLE HIGH COURT OF KERALA AT ERNAKULAM

_____ Of Year 2025

In

Crl.MC No.3414/2025

DR.MOHAMED RIZWAN T, : Petitioner

Vs

STATE OF KERALA, and another : Respondent

PRELIMINARY REPORT OF THE AMICUS CURIAE ALONG WITH ANNEXURES

Sd/-
E-VERIFIED
AKASH S.
K/980/2008

FSO VERIFIED-25

BEFORE THE HONOURABLE HIGH COURT OF KERALA AT ERNAKULAM

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BEFORE THE HON'BLE HIGH COURT OF KERALA AT ERNAKULAM

Crl. MC No. 3414/2025

Petitioner: Dr. Mohamed Rizwan T

v.

Respondents: State of Kerala and ors.

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BEFORE THE HON'BLE HIGH COURT OF KERALA AT ERNAKULAM

Crl. MC No. 3414/2025

Petitioner: Dr. Mohamed Rizwan T

v.

Respondents: State of Kerala and ors.

In re: Guidelines for the functioning of the Expert Medical Panel constituted for investigation of complaints against Registered Medical Practitioners for acts on commission or omission in the medical care of patients.

PRELIMINARY REPORT FILED BY THE AMICUS CURIAE

Introduction

The above Criminal Miscellaneous Case is one among the matters wherein the petitioners, aggrieved by the findings of the Expert Panel attributing criminal negligence to them, seek to quash the Final Report and all consequential proceedings. The petitioners are presently facing prosecution for offences punishable under Section 304-A of the Indian Penal Code, 1860.

This report is structured in five parts: (1) Background, (2) Concerns Raised, (3) Existing Guidelines and Suggestions Received, (4) Proposed Guidelines on the Functioning of the Expert Panel, and (5) Conclusion.

In the preparation of this report, the Amicus Curiae has drawn upon statutory provisions, parliamentary debates, judicial pronouncements, comparative guidelines from other jurisdictions, and relevant academic literature. Additionally, consultations were held with medical practitioners currently facing criminal proceedings, family members of victims, investigating officers, and representatives from the Indian Medical Association and *Chikithsaneethi*.

1. Background

1.1. As a background, section 304-A was introduced by Act XXVII of 1870, at the instance of Sir J Fitzjames Stephen, eminent jurist and legal member of Viceroy's Executive Council, who found that the punishment for 'Gross Negligence Manslaughter' in English law was 'strangely omitted' in the Code, despite the original draft prepared by Lord Macaulay contained such provision (Abstract of the proceedings. Council of the Governor General of India. Laws and Regulations. Vol. 9. 02.08.1870). Currently, in the United Kingdom, the offence of Gross Negligence Manslaughter is committed where the offender consciously and voluntarily disregarded the need to use reasonable care, which is likely to cause foreseeable grave injury or harm, and such act leads to the death of a person (***R v Adomako* [1995] 1 A.C. 171**).

1.2. Whereas, section 304-A is drafted broadly, encompassing '*any rash or negligent act*', putting treating

medical practitioners in a vulnerable position, at a risk of going through the rigour of criminal prosecution each time a treatment goes wrong. In ***Suresh Gupta v. Govt. of NCT of Delhi and ors.* (2004) 6 SCC 422,** the Hon'ble Supreme Court held that "*For fixing criminal liability on a doctor or surgeon, the standard of negligence required to be proved should be so high as can be described as 'gross negligence' or 'recklessness'*." The Hon'ble Apex Court, in ***Jacob Mathew v. State of Punjab and ors.* (2005) 6 SCC 1** upheld the ***Suresh Gupta* (supra)** judgment and laid down guidelines with respect to prosecution of medical professionals for offences in which criminal rashness or criminal negligence is an ingredient. It was directed that:

> "*a private complaint may not be entertained unless the complainant has produced prima facie evidence before the Court in the form of a credible opinion given by another competent doctor to support the charge of rashness or negligence on the part of the accused doctor. The investigating officer should, before proceeding against the doctor accused of rash or negligent act or omission, obtain an independent and competent medical opinion preferably from a doctor in government service qualified in that branch of medical practice who can normally be expected to give an impartial and unbiased opinion applying the [test prescribed in* ***Bolam v. Friern Hospital Management Committee*, [1957] 1**

> **W.L.R. 582** *to the facts collected in the investigation.*"

Following this landmark decision, most states issued circulars or directions, either providing for constitution of an Expert Committee or mandating the Investigating Officers to comply with the directions of the Hon'ble Apex Court.

1.3. Even prior to these judicial developments, the Government of Kerala had issued a series of circulars from 1989 onwards, regarding the investigation of Medical Practitioners accused of negligence. All these circulars provided for the constitution of the Expert Panels and the Apex Body, and stipulated timelines for completion of the proceedings. The circulars made it mandatory for the Investigating Deputy Superintendent of Police, on registration of a case against a medical professional for criminal negligence, to approach the Expert Panel convened by the respective District Medical Officer. However, none of the circulars listed above, emphasised on the test for criminal negligence laid down in ***Jacob Mathew case* (supra)** or the ***Bolam* test**.

2. Concerns raised with the existing framework

2.1. On behalf of the medical practitioners

2.1.1. Concerns in the Writ Petitions

Apart from the technical challenges to the Expert Panel's findings, the following general concerns have been raised::

2.1.1.1. The Expert Panel failed to provide an opportunity for the petitioner to be heard, denying them a chance to explain the facts and circumstances surrounding the patient's death. This is a clear violation of the principles of natural justice.

2.1.1.2. Despite there being no gross or high degree of negligence or recklessness being there on the part of the petitioner, the Expert Panel, wrongly attributed gross negligence, without distinguishing between tortious negligence and criminal negligence.

2.1.1.3. The Expert Panel failed to consider that criminal liability arises only when a medical professional's conduct falls below the standards expected of a reasonably competent practitioner in the relevant field [***Martin F D'Souza v. Mohd. Ishfaq* (2009) 3 SCC 1**]

2.1.1.4. The Panel did not take into account the specific circumstances faced by the petitioner at the time the line of treatment was chosen.

2.1.1.5. The Expert Panel placed undue reliance on the autopsy report and attributed the cause of death to the petitioner.

2.1.1.6. The petitioner came to know about the adverse inference made by the Expert Panel much later and by then, the investigation had progressed quite a bit. On certain cases, the medical practitioners came to know about the report, or even convening of the Expert Panel after they received the summons. In such cases, filing an appeal would be inconsequential.

2.1.2. Additional concerns of medical practitioners facing trial

2.1.2.1. Some similarly placed medical practitioners allege that the Expert Panel tends to attribute negligence to the practitioner named by the police, even when another doctor — consulted at a later stage — was better positioned to intervene or prevent the fatal outcome.

2.1.3. Other concerns

2.1.3.1. A major issue raised is that the Expert Panel's report is often introduced in court through a panel member and treated as substantive evidence by the prosecution. Given that the report emanates from a body perceived as neutral and lawfully constituted, it becomes difficult to rebut, even with counter-expert testimony. As a result, the Panel's finding could effectively predetermine the outcome of the trial.

2.1.3.2. Concerns have also been raised about senior members of the Expert Panel dominating deliberations, thereby suppressing dissenting views from junior members, who may feel compelled to conform.

2.2. On behalf of the victims

2.2.1. A significant gap in the current framework is that the right to appeal the findings of the Expert Panel is available only to the medical practitioners, not to the victims or their families. Since the Panel is predominantly composed of medical professionals and is tasked with evaluating the

conduct of their peers, a finding of 'no negligence' effectively forecloses any recourse for the de-facto complainant—even if they are clearly aggrieved.

2.2.2. De-facto complainants also allege that they are denied a reasonable opportunity to be heard, even though they acknowledge their limited understanding of medical science. A suggested reform is to permit them to be accompanied or represented by a lawyer or a qualified medical professional during proceedings before the Expert Panel.

2.2.3. Another grievance raised relates to the lack of comprehensiveness in Expert Panel reports. In some instances, the Panel identifies one count of negligence but fails to address multiple other allegations raised by the complainant. For example, in one case, a complainant alleged several acts of negligence, but the Panel's report consisted of only a one-page finding identifying a single lapse. In another case, the Panel found that negligence had occurred, but did not clarify which practitioner was responsible, leaving the Investigating Officer unable to proceed.

2.2.4. Victims' families also expressed concern over delays in the seizure of medical records. By the time the Investigating Officer collects the relevant case files, they fear that the hospital may have had an opportunity to tamper with or alter records.

2.2.5. Another critical concern is the lack of access to documents relied upon by the Expert Panel. In some

instances, even the discharge or treatment summary was allegedly withheld from the de-facto complainant after the patient died while under treatment.

2.3. On behalf of the Investigating Officers

2.3.1. A primary concern expressed by Investigating Officers is the delay in convening the Expert Panel after registration of the case. These delays hinder the pace of investigation, especially in sensitive matters involving allegations of medical negligence.

2.3.2. Investigating Officers also face difficulties in obtaining cooperation from hospitals, particularly in accessing the treatment records and case files of the patient. In some cases, hospitals delay or deny access, thereby obstructing the process of investigation.

2.3.3. The reports issued by the Expert Panel are sometimes too vague or ambiguous, making it difficult for the Investigating Officer to determine which individual(s) should be named as accused or proceeded against. This lack of clarity impedes the decision-making process in filing the final report.

2.3.4. Some members of the Expert Panel have reportedly complained of being overshadowed or "bulldozed" by the opinions of more dominant members within the panel. In such cases, they have been reluctant to provide detailed individual statements, fearing that they may be targeted by the fraternity and associations.

3. Existing guidelines and suggestions received

3.1. Guidelines of the National Medical Commission

3.1.1. The National Medical Commission (NMC), through its letter dated 29.09.2021, addressed to the Secretary, Ministry of Health and Family Welfare, submitted a draft "'guidelines' needed for prosecution of doctors for causing death of patients due to gross medical negligence or reckless therapy." A true copy of the letter sent on behalf of the National Medical Commission dated 29.09.2021 and numbered as NMC / MCT / EMRB / C-12015 / 0023 / 2021/ ETHICS/22426 addressed to the Secretary, Ministry of Health and Family Welfare is produced herewith and marked as **Annexure AC(i)**. Key changes brought in the said guidelines are that (a) the **Expert Panel would be required to provide their report within two weeks** and (b) that the **Permanent Member of the Expert Panel should change in every two years**.

3.2. Code for Crown Prosecutors – Crown Prosecution Service legal guidance on Gross Negligence Manslaughter

3.2.1. The Crown Prosecution Service (CPS) in the United Kingdom periodically updates its legal guidance on offence of Gross Negligence Manslaughter. A true copy of the Legal Guidance for the offence of Gross Negligence Manslaughter dated 14.03.12019 downloaded from the portal of the Crown Prosecution Service is produced herewith and marked as **Annexure AC(ii)**. In the said

guidance, the CPS outlines five essential elements that the prosecution must establish before a jury, relying on the decision of the Court of Appeal in ***Rose v R* [2017] EWCA Crim 1168**, which refined the test for Gross Negligence Manslaughter:

a. The defendant owed the deceased a duty of care;
b. The defendant negligently breached that duty of care;
c. It was reasonably foreseeable, based on knowledge at the time of the breach, that the breach gave rise to a serious and obvious risk of death;
d. The breach caused the death;
e. The circumstances of the breach were truly exceptionally bad so as to amount to gross negligence.

3.2.2. The guidance further emphasises that the assessment of whether a "serious and obvious risk of death" existed must be made based on knowledge available at the time of the alleged breach, and not with hindsight. It clarifies that a mere possibility of a serious outcome, or its later discovery through investigation, does not amount to an "obvious risk of death". According to the CPS, such a risk must be immediate, evident, and unambiguous, not one that becomes apparent only upon further analysis.

3.3. Suggestions from Indian Medical Association

3.3.1. The Expert Panel, while evaluating allegations, should also examine external or contributing factors that may have affected the final outcome for the patient, beyond the actions of the individual medical practitioner.

3.3.2. The severity of the situation must be independently assessed for each allegation. Any harm alleged must be evaluated in light of the following:

(i) Whether the fault(s), if any, of the medical practitioner directly influenced the outcome?

(ii) Whether extraneous factors may have contributed to the outcome, including but not limited to:

(a) The disease diagnosed and the associated risk to health/life, according to the prevailing knowledge in the medical literature and as opined by peer professionals, within the inherent limitations/side-effects/complications of medical science

(b) The health/immunity/present condition of the patient and the past medical and other histories relevant to the case.

(c) The reversibility and the probable impact of the line of treatment on the patient's health condition/life.

(d) The availability, condition, and maintenance of infrastructure; skill, qualifications, and expertise of the doctor/paramedical personnel/health-care team.

(e) The progress and severity of the disease along with compliance with medical advice.

(f) The cooperation by the patient and family/caregivers.

(g) The work pressures in the treatment setting, related to patient flow (e.g., the doctor to patient ratio); or

availability of infrastructure/facilities in a particular district/town/or remote area.

(h) The scope for corrections, in case of error; the reversibility of the outcome.

(i) The role expected to have been played by the doctor and the scope of duties / obligations imposed as per law. This may be influenced by the Hospital / Clinic / Institution (Public, Private, Charitable, Specialized, General)?

(*Extracted from Guideline 4 in National Medical Commission Registered Medical Practitioner (Professional Conduct) Regulations 2023*)

3.3.3. The fee structure or cost of treatment at the medical facility should not influence the assessment of severity or fault.

3.3.4. The extent of liability attributable to the medical practitioner must be assessed in the context of the inherent limitations of the clinical presentation, treatment environment, and available resources. The Expert Panel should strive to arrive at a balanced, consensus-based decision.

3.4. The position statement of the British Medical Association

3.4.1. The British Medical Association issued its position statement on the law of Gross Negligence Manslaughter on 21.11.2019. A true copy of the position statement on the

law on Gross Negligence Manslaughter dated 21.11.2019 is produced herewith and marked as **Annexure AC(iii)**. In its statement, the BMA endorses the legal standard laid down in ***Rose v. R* (supra)**, reaffirming that a medical practitioner cannot be held negligent if they acted in a manner consistent with a practice accepted as proper by a responsible body of medical opinion.

3.5. Other suggestions received

3.5.1. The morale of medical practitioners emerged as a key area of concern. Given the high-risk nature of their profession, it is argued that subjecting them to the rigours of criminal prosecution in the absence of clear criminal negligence is unjust. This has led to apprehensions that doctors may increasingly adopt defensive medical practices, opting for safer or more conservative treatment paths, even when riskier but more beneficial options exist for the patient. For instance, the rate of caesarean deliveries in several southern states of India is almost double the national average of 21.5%—with Telangana at 60.7%, Tamil Nadu at 44.9%, Andhra Pradesh at 42.4%, Kerala at 38.9%, and Karnataka at 31.5% (Dutta, Rohini et al. (2025) State-wise variation and inequalities in caesarean delivery rates in India: analysis of the National Family Health Survey-5 (2019–2021) data. *The Lancet Regional Health - Southeast Asia*. Vol. 32, 100512). In contrast, Nagaland records the lowest average at 5.2%. While patient preference and other socio-medical factors also contribute, this trend

underscores the need for further study into how legal fear may influence clinical decisions.

3.5.2. Further, with the *Bharatiya Nyaya Sanhita 2023* replacing the *Indian Penal Code 1860*, Section 106(1) now mandates imprisonment for medical professionals found guilty of gross negligence—unlike Section 304-A of the IPC, which gave courts the discretion to impose imprisonment or fine.

3.5.3. It has also been suggested that members of the Expert Panel be provided formal training and orientation on the concept of criminal negligence, including how to apply standards such as the Bolam test. However, there are practical constraints in implementing this suggestion—particularly because panel members are often appointed on a case-specific basis, depending on the nature and complexity of the medical issue involved.

4. Suggested guidelines on the functioning of Expert Panel

4.1. Constitution of the Expert Panel

4.1.1. As per the circulars issued by the Government of Kerala, the District Medical Officer (DMO) is empowered to nominate a senior medical practitioner from the relevant speciality to serve on the Expert Panel. The remaining members generally hold ex officio positions. To avoid arbitrariness and promote transparency, it is suggested that each district maintain a seniority list of practitioners by

speciality. This would not only streamline nominations but also allow the government to identify and train potential panel members in advance.

4.1.2. The inclusion of a member with experience in ethics-related committees, such as those constituted under the Kerala State Organ and Tissue Transplant Organisation (K-SOTTO), may be considered. Such members, having exposure to both medical practice and ethical/legal frameworks, can bring valuable interdisciplinary insight to the Expert Panel's deliberations.

4.2. Police to have a list of documents to be seized

4.2.1. While it may not be feasible to prescribe a universal list of documents to be seized in every case, it is advisable to define a basic set of essential medical records that should ordinarily be secured at the outset of an investigation. The documents to be secured would include case files which would comprise doctor's notes, nurses' diary, assessment forms, consent forms, medical reports, diagnostic reports and lab results, referral or cross consultation records, treatment notes, discharge summaries etc, and other documents such as duty roster, shift reports, attendance sheets etc. The Expert Panel may subsequently request additional records, and the Investigating Officer should take prompt steps to obtain and produce them.

4.2.2. The Investigating Officer should act swiftly to secure the initial set of documents as soon as a complaint is received.

4.3. Time-frame for completion of proceedings

4.3.1. The Government of Kerala, through its circulars, prescribes a 30-day time limit for the Expert Panel to conclude its proceedings. In contrast, the Draft Guidelines issued by the National Medical Commission (Annexure AC(i)) recommend a shorter time frame of two weeks. Strict adherence to the prescribed time limits—whether by the State Government or the NMC—would be beneficial to all stakeholders, including the medical practitioners under scrutiny, the complainants seeking redress, and the investigating agencies pursuing the matter.

4.4. Right of the medical practitioner and de-facto complainant to be represented

4.4.1. If either the medical practitioner or the de-facto complainant is permitted to appear—either personally or through legal or medical representatives—certain apprehensions must be addressed:

a. There is a risk that the proceedings before the Expert Panel may begin to resemble a mini-trial, thereby undermining its preliminary and advisory nature.
b. The presence of the parties and medical experts engaged by either party, could potentially intimidate or

overwhelm the panel members, and even influence their independent assessment.

4.4.2. As an alternative, it may be considered appropriate to permit both the medical practitioner and the de-facto complainant to submit written representations to the Expert Panel. These submissions must be taken on record and duly considered by the Panel while arriving at its conclusions.

4.5. Standardisation of the Report

4.5.1. The report of the Expert Panel should include the individual opinion of each member, or at least the expert members in the Panel, clearly recorded. The final conclusion of the Panel should be based on consensus, and should directly address whether gross negligence or recklessness, leading to the loss of life, can be attributed to the medical practitioner under investigation. The Hon'ble Apex Cout in ***V Kishan Rao vs Nikhil Super specialty*** **(2010) 5 SCC 513** held that:

> "*The first duty of the expert is to explain the technical issues as clearly as possible so that it can be understood by a common man. The other function is to assist the Fora indeciding whether the acts or omissions of the medical practitioners or the hospital constitute negligence. In doing so, the expert can throw considerable light on the current state of knowledge in medical science at the time when the patient was treated*."

4.5.2. The report must also specify which individual(s), from among the list of names provided by the Investigating Officer, the Panel believes have committed gross negligence or recklessness, along with a reasoned explanation for that conclusion.

4.5.3. The Panel should apply a clear and consistent test for determining criminal negligence. This may include reference to the ***Bolam test*** or the five-point standard laid down in ***Rose v. R.* (supra)**, to assess whether the conduct meets the threshold of gross negligence or recklessness. The reasoning applied must be reflected explicitly in the report.

4.5.4. To ensure uniformity and avoid ambiguity, a reporting template may be developed and prescribed for use by all Expert Panels.

4.5.5.A copy of the report has to be served on the medical practitioners found to have acted negligently and the de-facto complainant.

4.6. On Appeal

4.6.1. The right to appeal against the finding of the Expert Panel should be available to all affected parties – the medical practitioner, prosecution or the de-facto complainant.

4.6.2. The Investigating Officer shall commence the investigation only after the time-limit specified for filing appeal elapses, and if appeal is filed, only after the appeal is disposed of by the Apex Body.

4.7. Private Complaints

4.7.1. When a complaint is filed under section 156(3) of the *Code of Criminal Procedure 1973* (*CrPC*) or section 175(3) of *the Bharatiya Nagarik Sakshya Sanhita 2023* (*BNSS*), there is presently no requirement to constitute an Expert Panel. In such cases, the complainant is only required to establish gross negligence through the testimony of an expert witness. While this technically satisfy the directions of the Hon'ble Supreme Court in ***Jacob Mathew* (supra)**, it undermines the very rationale for creating expect panels, especially since the aggrieved complainant retains the option to file a private complaint, even after the Expert Panel concluded that there is no negligence.

4.7.2. This Hon'ble Court may, therefore, consider issuing directions to Magistrates, in cases where private complaints alleging offences under section 304-A of the *Indian Penal Code 1860* are filed, to exercise the power vested upon them to direct police investigation, and the police shall, act in accordance with the circular binding on them. Where an Expert Panel has already convened and found no negligence, the Magistrate shall proceed to take cognizance only after comparing the findings of the Expert Panel and the evidence provided by the Expert Witness produced by the complainant.

4.8. Alternative method

4.8.1. It is important to underscore that the primary role of the Expert Panel is to assist the Investigating Officer in

determining whether the conduct of a medical practitioner warrants prosecution for criminal negligence. The report of the Expert Panel, ideally, should be treated as preliminary and advisory in nature. However, in practice, the report is often introduced as evidence at trial and plays a determinative role in the outcome. This raises serious concerns about prejudicing the trial.

4.8.2. To mitigate this, an alternative mechanism may be considered—wherein the Expert Panel is tasked with objectively responding to a structured questionnaire framed by the Investigating Officer. Under this approach, the individual findings of each panel member or the expert members in the Panel would still be made available to the Investigating Officer to facilitate further steps in the investigation. However, no collective summary or unified report would be disclosed unless specifically required during appellate proceedings.

4.8.3. One concern with this model is that it may dilute the accountability of the Expert Panel, particularly if their conclusions are not accompanied by reasons or justifications. This, in turn, may affect judicial scrutiny and the confidence of stakeholders in the process.

4.8.4. On the other hand, this approach may alleviate the undue burden placed on medical practitioners, who are often forced to defend themselves at trial against the weight of a formally endorsed expert opinion, even before judicial determination.

5. Conclusion

5.1. The intersection of criminal law and medical practice presents complex challenges that require a careful balance between accountability and fairness. While it is imperative that instances of genuine gross negligence be addressed with the seriousness they deserve, it is equally vital to ensure that medical professionals are not subjected to the trauma of prosecution based on vague or unstructured expert findings.

5.2. The present framework—though guided by judicial precedent and administrative circulars—still leaves considerable scope for ambiguity, arbitrariness, and procedural imbalance. Both the rights of the accused medical practitioner and the de-facto complainant require clearer recognition, particularly in terms of representation, access to findings, and the right to appeal.

5.3. Strengthening the independence, transparency, and methodological rigour of Expert Panels is crucial. Standardisation of reports, clear timelines, evidence-based assessments, and periodic training can improve both the quality and fairness of outcomes. At the same time, any reliance placed on Expert Panel reports in criminal trials must be carefully weighed to avoid prejudicing the judicial process.

5.4. Ultimately, reform must be guided by the dual goals of protecting patient rights and preserving the morale and integrity of the medical profession, without compromising on either. Legislative clarity, procedural safeguards, and

ethical oversight must together shape a framework that is just, effective, and sustainable.

5.5. Based on the discussions and suggestions from this Hon'ble Court, as well as the concerned parties in the Criminal Miscellaneous Cases in response to this report, the Amicus Curiae craves leave to file additional reports that may be found necessary. Also, Certain key details – particularly, regarding the frequency at which the Expert Panel finds negligence on the part of the medical practitioner – are still awaited.

Dated this the 10th day of July 2025

Adv. Akash Sathyanandan
Amicus Curiae

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राष्ट्रीय आयुर्विज्ञान आयोग
National Medical Commission
ETHICS & MEDICAL REGISTRATION BOARD

NMC/MCI/EMRB/C-12015 /0023 /2021/ETHICS/०२२५२६ Date: २१।१।२०२१

The Secretary
Ministry of Health & Family Welfare
Nirwan Bhawan, A-Wing
Maulana Azad Road, New Delhi -110077

Sub:- **Regarding specific directions issued by the Hon'ble Apex Court to frame specific "guidelines " needed for prosecution of doctors for causing death of innocent patients due to gross medical negligence or reckless therapy.**

Sir,

Please refer to your letter no. Nil dated 02.03.2021 received in this office dated 15.03.2021 filed by Dr. Kunal Saha, President PBT, on the subject cited above.

GUIDELINES FOR PROTECTING DOCTORS FROM FRIVOLOUS OR UNJUST PROSECUTION AGAINST MEDICAL NEGLIGENCE

The prosecution in case of death of a person by a medical negligence by a doctor comes under section 304-A of the Indian Penal Code. Hon'ble Supreme Court in its judgment dated 05.08.2005 in the matter of Jacob Mathew Vs. State of Punjab has taken note that the investigation officers and the private complaint cannot always be supposed to have knowledge of medical sciences so as to determine whether law under section 304-A of IPC. The criminal process once initiated subjects the medical professional to serious embarrassment and sometimes harassment.

To protest doctors from frivolous or unjust prosecution against medical negligence, Hon'ble Supreme Court in the said judgment observed that stator Rules or Executive Instructions incorporating certain guidelines need to be farmed and issued by the Government of India and/or the state government in consultation with the medical council of India. The Hon'ble court had also held that doctor accused of rashness or negligence, may not be arrested in a routine manner (simply because a charge has been leveled against him.) Unless arrested, the arrest may be withheld.

Further, the Hon'ble Supreme Court in the matter of lalita Kumari Vs. State of U.P &OR's, vide Judgment dated 12.11.2013 (and partially modified on 05.03.2014) held that the preliminary inquiry in medical negligence cases should be made time bound and in any case, it should not exceed fifteen days generally and in exceptional cases of it must be reflected in the General dairy entry.

The EMRB, NMC recommends to frame the following guidelines for protecting of which criminal rashness or unjust prosecution against medical negligence:

1. The prosecuting/Investigating Agency on receipt of any complaint of which criminal rashness or negligence is an ingredient against medical practitioners under the Indian Medical Council Act, 1956/NMC Act prior to making arrest refer the complaint to district Medical Council Board for its recommendations as regards the merit of the allegation of criminal rashness or negligence, contained in the complaint. The District Medical Board should be in govt. medical college and in district hospital if the district doesn't have a medical college. (The reason being the availability of all the experts with

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National Medical Commission
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them.) Department of forensic Medicine and Toxicology in every medical college which can be a nodal department for such board.

2. The District Medical Board on receipt of such a reference examine the allegation contained therein within two weeks from the date of its receipt and forward its recommendations to the prosecuting/ investigating Agency.

3. The prosecuting/Investigating Agency or Doctors(against whom the complaint is lodge), in case, it is dissatisfied with the recommendation of the district Medical Board may starting the reasons for such dissatisfied refer the matter to the state Medical Board for its recommendation within a period of two weeks from the receipt of recommendation of the district Medical Board.

4. The state Medical Board should have a pool of specialist from state from each specialty apart from permanent members appointed by state government. Two specialist of the concerned Branch should be included in the board on the day of receipt of the complaint or appeal.

5. The state medical board on receipt of any such reference from the prosecuting/investigating Agency would examine the mater within two weeks from the date of receipt of such reference. The state medical board shall provide reason for endorsing or rejecting the recommendation of the district medical board.

6. The prosecuting/ Investigating Agency on receipt of recommendation of the district/ state medical board may further proceed in the matter in accordance with law. However, in case arrest of a registered medical practitioner in the employment of state/Central Government is being made, the controlling officers of such medical practitioner would be informed by the prosecuting/ Investigating Agency. Likewise, in case the registered medical practitioner is engaged in private practice, the concerned state medical council, or in case there is no state medical council in that state/UT, EMRB NMC informed.

7. A doctors accused of rashness or negligence may not be arrested in a routine manner (simply because allegation has been leveled against him.) Unless the alleged negligence is of gross nature; and arrest is necessary for furthering the investigation or for collecting evidence or unless the investigation officers is satisfied that the doctor proceeded against would not make himself available to face the prosecution unless arrested, the arrest may be withheld. Further investigating agency prior to arrest of the doctor in such cases shall place factual position for consideration of concerned superintendent of police/DCP.

8. The Boards should apply Bolam's test to facts `Standard of responsible body of medical opinion).

Further Suggestions :-

1. District Board -
   - A) Permanent Member s of board should change at least every two year.
   - B) If Board is in Medical College, then one member from Civil Surgeon office should be included.

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राष्ट्रीय आयुर्विज्ञान आयोग
National Medical Commission
ETHICS & MEDICAL REGISTRATION BOARD

2.	State Board	-	A)	Permanent Members of Board should be changed after 2 years and a member from DGHS be included.

Sincerely Yours,

(Pragya Juneja)
Sr. consultant,
Ethics Section, EMRB

Copy forwarded for information to:-

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Gross Negligence Manslaughter

14 March 2019 | *Legal Guidance*

Introduction

The offence of gross negligence manslaughter (GNM) is committed where the death is a result of a grossly negligent (though otherwise lawful) act or omission on the part of the defendant - *R v Adomako* [1994] UKHL 6.

Gross negligence manslaughter is a common law offence. The offence is indictable only.

The Code for Crown Prosecutors

The Code for Crown Prosecutors is a public document, issued by the Director of Public Prosecutions that sets out the general principles Crown Prosecutors should follow when they make decisions on cases.

Continue reading

Prosecution guidance

This guidance assists our prosecutors when they are making decisions about cases.

The circumstances in which this offence may fall to be considered are almost infinitely variable but the most frequently encountered occur in the following contexts:

- Death following medical treatment or care; the offence can be committed by any healthcare professional, including but not exclusively doctors, nurses, pharmacists, and ambulance personnel;
- Deaths in the workplace the offence can be committed by anyone who is connected in some way to a workplace of any nature. The context is wide ranging but can include offices, factories, ships, airports, aeroplanes, construction sites, oil rigs, farms, schools and sporting grounds. The deceased victims may be employees, contractors, sub-contractors, and members of the public visiting or passing by the workplace when a fatal incident happens.
- Death in custody - a death in custody is a generic term referring to deaths of those in the custody of the State. In this context the offence can be committed by police or prison officers, dedicated detention and other custody assistants, and by healthcare professionals who are responsible for the care of those detained in a custodial setting.

Handling

For guidance on which department cases of GNM should be referred to see, Referral of Cases to CPS Headquarters elsewhere in the legal guidance.

Corporate manslaughter (including offences under Health and Safety legislation) and death in custody cases are not covered in this document. See the CPS Corporate Manslaughter Guidance.

When corporate manslaughter offences and/or Health and Safety at Work Act offences are being considered with GNM offences, please refer to the CPS Corporate Manslaughter Guidance.

The Law

The ingredients of the offence were authoritatively set out in the leading case of *R v Adomako* [1995] 1 AC 171in which Lord Mackay of Clashfern LC at page 187 said the following:

"In my opinion, the law as stated in these two authorities Bateman *(1925) 19 Cr. App. R. 8 and* Andrews v DPP *[1937] AC 576 is satisfactory as providing a proper basis for describing the crime of involuntary manslaughter. Since the decision in* Andrews *was a decision of your Lordships' house, it remains the most authoritative statement of the present law which I have been able to find*

It is regularly updated to reflect changes in law and practice.

A B C D E F
G H I J K L
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Y Z

and it has not been departed from. On this basis, in my opinion the ordinary principles of negligence apply to ascertain whether or not the defendant has been in breach of a duty of care towards the victim who has died. If such breach of duty is established the next question is whether that breach of duty caused the death of the victim. If so, the jury must go on to consider whether that breach of duty should be characterised as gross negligence and therefore as a crime."

In order to prove the offence, the prosecution must therefore establish the following elements:

a) The defendant owed a duty of care to the deceased;

b) By a negligent act or omission the defendant was in breach of the duty which he owed to the deceased;

c) The negligent act or omission was a cause of the death; and

d) The negligence, which was a cause of the death, amounts to gross negligence and is therefore a crime;

More recently, the elements of manslaughter by gross negligence were stated concisely by the President of the Queen's Bench Division in *R v Rudling* [2016] EWCA Crim 741at paragraph 18 as follows:

We can summarise the law shortly. The critical ingredients of gross negligence manslaughter can be taken from R v Prentice, Adomako and Holloway *[1994] QB 302 in this court and* Adomako *[1995] 1 AC 171, [1994] 99 Crim App R 362 in the House of Lords as well as* R v Misra *[2005] 1 Cr App R 21. They can be summarised as being the breach of an existing duty of care which it is reasonably foreseeable gives rise to a serious and obvious risk of death and does, in fact, cause death in circumstances where, having regard to the risk of death, the conduct of the defendant was so bad in all the circumstances as to amount to a criminal act or omission (see* Adomako *[2005] 1 Cr App Rep at 369). The elements of GNM were set out by the House of Lords in* R v Adomako *[1995] 1 AC 171.*

Elements of the Offence

Duty of Care

There is no general duty of care owed by one citizen to another and there is a *"sharp distinction between acts and omissions"* - Lord Mustill in *Airedale NHS Trust v Bland* [1993] AC 789. Unless there is a pre-existing duty of care, a failure to act, even if it results in death, cannot amount to GNM.

A duty of care will arise from an act of a person where the requirements of foreseeability, proximity, fairness, justice and reasonableness establish such a duty *Donohue v Stevenson* [1932] AC 582. An alleged breach of duty occasioned by an omission will only arise where a legal duty of care already exists. In *Caparo Industries PLC v Dickman* [1990] 2 AC 605 it was said that, in novel situations, there was a three-fold test to decide if a duty of care should be held to exist.

- Whether the damage was foreseeable;
- Whether the claimant was in an appropriate position of proximity to the defendant; and
- Whether it was fair and just to impose liability on the defendant.

Those with a duty of care must act as the reasonable person would do in their position. If they fail to do so, they will have breached their duty. The standard of care to be applied should be a reflection of the extent of the duty of care.

In many situations the law already recognises that a duty of care will exist (for example by employers to their employees and by health care professionals to their patients) and the need to apply the *Caparo* test will in most cases not arise.

It is in general for the judge to decide whether there is evidence capable of giving rise to a duty of care, and, if there was, it is for the judge to give the jury appropriate directions, whether the defendant in fact owed the deceased a duty of care.

When a person has created or contributed to the creation of a state of affairs which he knows, or ought reasonably to know, has become life threatening, a duty on him to act by taking reasonable steps to save the other's life will normally arise - *R v Evans* [2009] EWCA Crim 650, para.31.

The duty can exist even where the deceased and the defendant were engaged in an unlawful activity together - *R v Wacker* (2003) 1 Cr App R 329; *R. v Willoughby* [2004] EWCA Crim 3365.

Breach of duty

The ordinary principles of the law of negligence apply to determine whether the defendant was in breach of a duty of care towards the victim.

Whether or not sufficient care has been taken by the individual to discharge the particular duty of care placed upon him is tested by the objective standard of reasonableness.

In considering a breach, the jury must consider objectively what a competent person fulfilling the same role as the defendant would have done; and so for example, the conduct of a doctor, electrician or builder who is accused of the offence is assessed by comparison with what the competent doctor, electrician or builder would have done in the same position and circumstances as the defendant. If what the defendant did is not contrary to the actions considered appropriate by a responsible medical, electrical or building opinion (as relevant), then their conduct will not be considered negligent.

In *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582, the trial judge, McNair, put it in this way: *"a doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art putting it the other way round, a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view."*

This means that in order to prove that a doctor has breached their duty of care it must be proved that there is no responsible body of doctors who would regard the treatment as acceptable.

However, the standard of care is objective and, as such, does not take into account the weaknesses or inexperience of the particular defendant. For example, in *Wilsher v Essex AHA* [1987] QB 730, the Court of Appeal rejected the proposition that a trainee doctor working in a special care baby unit was to be judged by what could be expected of him, given his limited qualifications and experience; the duty is tailored to the act and not to the actor, so that the applicable standard was that which could reasonably be expected of a person filling the particular, specialised role. Thus the fact that the defendant has not been sufficiently or adequately trained is not a relevant factor in establishing whether they breached their duty of care but it can be relevant to the question of whether gross negligence can be established. On the other hand, if the defendant has particular skills or knowledge that ordinary reasonable person would not have, his acts should be judged in the light of those skills or knowledge.

Causation

The breach of duty must cause the death. It does not have to be the only cause nor even the principal cause of death but it must have more than minimally, negligibly or trivially caused the death. The burden rests with the prosecution to establish causation.

The test for causation in criminal cases was succinctly put by Lord Woolf MR in *R v HM Coroner for Inner London, ex parte Douglas-Williams*[1998] 1 All ER 344:

"In relation to both types of manslaughter (i.e. unlawful act and gross negligence) it is an essential ingredient that the unlawful or negligent act must have caused the death at least in the manner described. If there is a situation where, on examination of the evidence, it cannot be said that the death in question was caused by an act which was unlawful or negligent as I have described, then a critical link in the chain of causation is not established. That being so, a verdict of unlawful killing would not be appropriate and should not be left to the jury."

It is unnecessary for the breach of duty to have been the sole or even the main cause of death, provided it contributed significantly to the victim's death. It is not the function of the jury to evaluate competing causes or to choose which was dominant, provided they are satisfied that the defendant's actions could fairly be said to have been a significant contribution to the victim's death: *R v Cheshire*[1991] 1 WLR 844 at 848B-C 851H-852B.

In cases where there has been an omission to act, the prosecution must prove that the negligent failure to act was a substantial cause of death. Where there is evidence that after a certain time the deceased, regardless of any intervention, was more likely than not to die anyway, then failures to act beyond that point (i.e. the point when his condition became irreversible) cannot establish causation. In*R v Misra* [2004] EWCA Crim 2375 the Court of Appeal cited the summing up of Langley J with approval. Langley J said:

"If you are not sure that [X] would have survived at all, either however well he had been treated or - because he might not have received appropriate treatment, then the prosecution has failed to prove its case on this aspect and that is the end of the matter. You must find both defendants not guilty. Equally, if at some point in the events of the Saturday or the Sunday you reach the conclusion that you are not sure that [X] would have survived beyond that time, then from that time onwards the prosecution will fail to prove that anything [Dr M] or [Dr S] did or failed to do was a cause of [Xs] death, and, whatever you think of the subsequent events, they cannot lead you to a verdict of guilty. If you have any reasonable doubt about when [Xs] condition became irreversible, I repeat that you must give the defendants the benefit of those doubts."

The phrase '*de minimis*' sometimes known as the *de minimis* rule, means that causation is not established if the prosecution can only show that, had the defendant not been negligent, the deceased would only have survived hours or

days longer, in circumstances where the intervening life would have been of no real quality - *R v Sinclair and others* [1998] EWCA Crim 2590.

A useful initial question, therefore, to ask in this context is; irrespective of the negligence, (act or omission) would or may the deceased have died when they did/or within the *de minimis* rule. If the answer on the evidence is that, irrespective of the negligence, the deceased would or may have died when they did, or would only have survived hours or days longer in circumstances where the intervening life would have been of no real quality, then causation is not made out.

Grossness

In determining whether sufficient evidence exists for a realistic prospect of conviction, prosecutors need to also consider how the courts have determined the degree of negligence required for the offence.

The breach of duty must be so bad as to be gross, i.e. criminal. This was defined in *Adomako* [1994] 3 All ER 79 as follows: having regard to the risk of death involved, was the conduct of the defendant so bad in all the circumstances as to amount to a criminal act or omission? The prosecution must prove the following two elements:

a) that the circumstances were such that a reasonably prudent person in the defendant's position would have foreseen a serious and obvious risk of death arising from the defendant's act or omission;

b) that the breach of duty was, in all the circumstances, so reprehensible and fell so far below the standards to be expected of a person in the defendant's position with his qualifications, experience and responsibilities that it amounted to a crime.

The serious and obvious risk of death

At the time of the breach, the jury must conclude that a reasonably prudent person, undertaking the role that the accused undertook, would have foreseen a serious and obvious risk of death, and not merely a risk of injury, even serious injury.

The meaning of serious was considered by the Court of Appeal in *R v Rudling* [2016] EWCA 741:

"a serious risk of death is not to be equated with an inability to eliminate a possibility. There may be numerous remote possibilities of very rare conditions which cannot be eliminated but which do not present a serious risk of death."

The meaning of obvious was considered by the Court of Appeal in *R v Rose (Honey Maria)* [2017] EWCA Crim 1168 citing with approval the wording used in Rudling:

"[A] mere possibility that an assessment might reveal something life-threatening is not the same as an obvious risk of death. An obvious risk is a present risk which is clear and unambiguous, not one which might become apparent on further investigation."

In *R v Rose*, Leveson LJ confirmed the ruling in *Rudling* and concluded that the question of whether there was a serious and obvious risk of death must exist and be assessed with respect to knowledge at the time of the breach of duty. It was therefore *not appropriate to take into account what the defendant would have known but for his or her breach of duty*. The court usefully summarised the main principles applicable to GNM as follows:

77. In the circumstances, the relevant principles in relation to cases of gross negligence manslaughter can be summarised as follows:

1. The offence of gross negligence manslaughter requires breach of an existing duty of care which it is reasonably foreseeable gives rise to a serious and obvious risk of death and does, in fact, cause death in circumstances where, having regard to the risk of death, the conduct of the defendant was so bad in all the circumstances as to go beyond the requirement of compensation but to amount to a criminal act or omission.

2. There are, therefore, five elements which the prosecution must prove in order for a person to be guilty of an offence of manslaughter by gross negligence:

a) the defendant owed an existing duty of care to the victim;

b) the defendant negligently breached that duty of care;

c) it was reasonably foreseeable that the breach of that duty gave rise to a serious and obvious risk of death;

d) the breach of that duty caused the death of the victim;

e) the circumstances of the breach were truly exceptionally bad and so reprehensible as to justify the conclusion that it amounted to gross negligence and required criminal sanction.

3. The question of whether there is a serious and obvious risk of death must exist at, and is to be assessed with respect to, knowledge at the time of the breach of duty.

4. A recognisable risk of something serious is not the same as a recognisable risk of death.

5. A mere possibility that an assessment might reveal something life-threatening is not the same as an obvious risk of death: an obvious risk is a present risk which is clear and unambiguous, not one which might become apparent on further investigation.

78. A further point emerges from the above analysis of the authorities which is particularly germane to the present case: none of the authorities suggests that, in assessing either the foreseeability of risk or the grossness of the conduct in question, the court is entitled to take into account information which would, could or should have been available to the defendant following the breach of duty in question. The test is objective and prospective.

The court stated further:

94. *Reverting to the question posed at the commencement of this judgment, we conclude that, in assessing reasonable foreseeability of serious and obvious risk of death in cases of gross negligence manslaughter, it is not appropriate to take into account what the defendant would have known but for his or her breach of duty. Were the answer otherwise, this would fundamentally undermine the established legal test of foreseeability in gross negligence manslaughter which requires proof of a serious and obvious risk of death* ***at the time of breach****. The implications for medical and other professions would be serious because people would be guilty of gross negligence manslaughter by reason of negligent omissions to carry out routine eye, blood and other tests which in fact would have revealed fatal conditions notwithstanding that the circumstances were such that it was not reasonably foreseeable that failure to carry out such tests would carry an obvious and serious risk of death. For these reasons, this appeal is allowed and the conviction is quashed.*

Further, the risk must be one of death: *A recognisable risk of something serious is not the same as a recognisable risk of death. (*R v Rose*).*

The test is objective, although the subjective awareness of the defendant will be a relevant factor for the jury to consider when they determine the objective risk of death. *R (Rowley) v DPP* (2003) EWHC Admin 693.

It is important to note that *R v Rose* does not determine that omitting to act can never be a foundation for gross negligence manslaughter. The Court stated (at paragraphs 85; 87) that the factual matrix in any case was crucial and highlighted examples where omitting to act, against a background of other cogent and unambiguous warnings, could fulfil the element of an obvious and serious risk of death at the time of the breach. See also the CA judgment in *Winterton* [2018] EWCA 2435 (Crim)

Criminality

The foundation of this offence is that the degree of negligence needs to be very high before the conduct can be considered to be a crime.

It is also important that the defendants conduct, the gravity of the breach, involving a serious and obvious risk of death, must be considered in all the circumstances in which the defendant was placed, per Lord Mackay in *Adomako*.

Various terms have been used to describe the type of conduct that may amount to gross negligence. The case of *Misra* [2004] EWCA Crim 2375 provides some guidance on the degree of negligence required for it to be regarded as gross. The Court of Appeal cited, with approval, the following passages from the trial judges summing up:

"Mistakes, even very serious mistakes, and errors of judgment, even very serious errors of judgment are nowhere near enough for a crime as serious as manslaughter to be committed."

The defendants conduct must fall so far below the standard to be expected of a reasonably competent and careful [person in the defendants position] that it was something truly, exceptionally bad.

In *R v Sellu* [2016] EWCA Crim 1716 the court quashed a conviction on two grounds. Cited with approval by Leveson LJ in *Honey Maria Rose*(Leveson LJ also being in judgement in *Sellu*), he said:

"the judge failed to direct the jury sufficiently as to the line that separates serious or very serious mistakes or lapses from conduct which was truly exceptionally bad and was such a departure from that standard [of a reasonably competent doctor] that it consequently amounted to being criminal."

In *Sellu* the Court of Appeal, in quashing a conviction, further underlined the importance of explaining to the jury the seriousness of the departure from ordinary standards required by the concept of gross negligence. The question of whether the negligence is a matter ultimately for the jury rather than the

experts, although expert evidence is, of course, important for identifying in what respects the conduct of the accused fell below that to be expected. It is not sufficient, however, simply to leave to the jury the question of whether the departure was gross or severe.

What is required is:

that the jury are assisted sufficiently to understand how to approach their task of identifying the line that separates even serious or very serious mistakes or lapses, from conduct which was truly exceptionally bad and was such a departure from that standard [of a reasonably competent doctor] that it consequently amounted to being criminal.

The judge is required to make it clear to the jury that they are not bound by the expert's opinion.

The Crown Court Compendium states:

The jury need to be sure that the breach is sufficiently grave to be one deserving to be criminal and to constitute manslaughter. A clear warning as to the high threshold is required. The courts have recently emphasised that to repeat the word is insufficient. The jury need to understand that they must be sure of a failure that was not just serious or very serious but truly exceptionally bad. This was emphasised in Sellu *[2016] EWCA Crim 1716 at [152].*

The relevance of the defendant's state of mind when assessing criminality/badness

Lord Mackay in *Adomako* referred in the course of his speech to the concept of recklessness in the sense of a subjective understanding or appreciation of the risk, but there is no doubt that the test of liability is objective.

In Attorney General Reference (No. 2 of 1999) (unreported), transcript 15th February 2000, Rose LJ stated:

"Although there may be cases where the defendants 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. The Adomako test is objective, but a defendant is who is reckless may well be the more readily found to be grossly negligent to a criminal degree."

In *Rowley v DPP* (4th April 2003), the High Court (QBD), considered a defence submission that subjective recklessness may help to establish a prosecution case, but that otherwise the state of mind of the proposed defendant is

irrelevant. Lord Justice Kennedy stated:

"That seems to us to be an unrealistic approach which the authorities do not require, which no judge would enforce, and which no jury would adopt. Once it can be shown that there was ordinary common law negligence causative of death, and a serious risk of death, what remains to be established is criminality or badness. In considering whether there is criminality or badness, Lord Mackay [in Adomako*] makes it clear that all the circumstances are to be taken into account."*

In reference to the decision of the Court of Appeal in *R v Prentice*, Lord Justice Kennedy said;

"The fact that Dr Prentice was inexperienced, reluctant to give treatment and wholly unaware of the likely fatal consequences were all factors which the jury were entitled to take into account in the defendant's favour. Likewise, in Dr Sullman's favour, his belief and understanding could be taken into account." (Paragraph 38).

Thus it is clear that whilst the absence of subjective recklessness cannot exempt liability, an assessment of a defendant's recklessness could be made by the jury to assist them in evaluating the criminality or badness of the breach.

Relevance of the Deceased's Conduct

If the elements of gross negligence manslaughter are made out, then it is no defence that the deceaseds death was caused in part by his own conduct. However, evidence to that effect may be relevant to the degree of the defendant's culpability and, as such; relevant to the question of whether he was grossly negligent: *R v Winter & Winter* [2010] EWCA Crim 1474.

Medical Manslaughter

All the factors outlined above apply to cases where the defendant is a medical or healthcare professional and many of the appellate cases cited above refer to recent decisions by the court in relation to the prosecutions of medical manslaughter cases.

In many cases the investigating police officers are unfamiliar with this area of the criminal law and therefore seek early advice from CPS concerning the elements of GNM and whether the evidential test could be met in any individual case. This early advice enables the police in some cases to be able to make the decision to close their investigation at an early stage where the evidential test could not be met.

Experts and Process

In all cases of medical manslaughter, the evidence of medical expert/s will be required. There will most usually be a pathologist report and expert evidence will be required concerning whether the actions or omissions of the medical professional caused the victim's death.

If causation can be proved, medical evidence will be needed to provide an opinion on how far below the standard of the reasonable medical professional the conduct fell. Sometimes the advice of several experts is required on different aspects of the case.

While considerable weight will be attached to the expert evidence, which will inform and assist the making of the decision in any case, the decision as to prosecution and whether the evidential test is met is ultimately one for the independent prosecutor.

Experts are required to have suitable and relevant expertise in their area of practice and will make a declaration as to their independence and expertise when they provide their reports.

The prosecutor will provide terms of reference for the expert outlining the elements of the offence of GNM and will address any aspects of the individual case that require particular expert advice.

In a case where the prosecutor considers that the evidence indicates that the threshold for a prosecution of GNM may be reached, senior counsel will be instructed to advise.

In cases where a charging decision of GNM is under consideration, the prosecutor and counsel will meet with the expert/s to discuss the report/s and the evidential test for GNM. Notes will be taken of any such meeting and any information which meets the disclosure test will be provided to the defence if a prosecution is commenced.

All review decisions in cases of gross negligence manslaughter are made by specialist prosecutors or senior specialist prosecutors in Special Crime Division and require the approval of the Head of the relevant Unit and final authorisation by the Deputy Head of Division.

Relevant factors in establishing grossness

The factors that are relevant to take into account for the review of an allegation of medical manslaughter or any GNM case are many and varied and it is not possible to be exhaustive about the factors that may be considered in any given

case.

However, some factors which often have a bearing on culpability in these cases are possible to identify.

The *Misra* test is important in any decision on grossness and mistakes, even very serious mistakes, will not be sufficient to pass the evidential test for grossness.

Where there is a course of conduct by an individual and a series of serious breaches the test of grossness may be more likely to be met.

The deliberate overriding or ignoring of systems which are designed to be safe and have proven to be safe may be evidence of a serious breach of duty. Similarly, ignoring of warnings from other members of staff or when an individual acts against the advice of other members of the team alerting them to serious dangers or risk.

In some cases the fatal incident may be the result of actions or inactions by several medical professionals and it is not possible to identify any one individual who has committed a gross breach of duty. GNM is an individual offence and it is not possible to aggregate the conduct of several medical professionals.

In evaluating the evidential test for grossness, the conduct of the medical professional will always be considered against the background of all the relevant circumstances in which that individual was working. The relevant working conditions and factors of which the investigation has evidence will be provided to the appropriate expert for information and will be considered in the review of the evidential test by the prosecutor.

Sentencing

Gross negligence manslaughter is a common law offence and carries a maximum of life imprisonment. The sentencing guidelines can be found here

BMA

The BMA position statement on the law of Gross Negligence Manslaughter

Background

Gross negligence manslaughter (GNM) is a common law offence – as opposed to a statutory offence which is defined by parliament and codified in legislation such as an Act of Parliament. It has been developed as a result of decisions as to principle, and the application of that principle, by the appellate courts. Whilst this means that the law can be further developed in the same way, it does mean that this is likely to be case specific and incremental, rather than through significant one-off reform.

BMA searches of news, legal, and medical databases, together with a request to the General Medical Council made under freedom of information legislation, found that 11 doctors had been charged with medical (gross negligence manslaughter in the UK between 2006 and the end of 2013. Of these, six (55%) were convicted[i].

The last three doctors convicted in 2012-13 all received custodial sentences rather than the usual suspended sentence. Before that the previous doctor to get a custodial sentence for medical manslaughter was in 2004. Since December 2014 four more doctors have been charged with medical manslaughter and are awaiting trial.

Investigations into the suspected offence are often lengthy and can take as long as three years. In the process, the doctor affected is under a great deal of stress and an NHS system that is already strained may be denied the services of that doctor.

The role of the Senior Coroner: BMA Members also underline that in their experience, a large proportion of GNM investigations begin after the Coroner has referred the matter to the police. this calls for clearer guidance and clarity on statutory roles, responsibilities and procedures and early prosecutorial involvement in police investigations in medical cases.

What the BMA has undertaken so far in relation to Gross Negligence Manslaughter

As part of its work on this issue, the BMA has responded to the Sir Norman Williams rapid policy review into the issues pertaining to Gross Negligence Manslaughter (GNM), commissioned by Health and Social Care secretary Jeremy Hunt in the aftermath of the Dr Bawa-Garba ruling[ii].

The BMA has also responded to the Leslie Hamilton independent review into how the law on gross negligence manslaughter and culpable homicide are applied to medical practice[iii].

In response to BMA member enquiries, the Medico Legal Committee discussed the option to lobby for legislative change to the law on GNM and sought advice from Duncan Atkinson, QC on whether to pursue this course of action.

Duncan Atkinson, QC, advised that Parliament had previously declined proposals for changes in legislation put forward by the Law Commission. Furthermore, legislative changes would be highly unlikely to make any real difference (as was the case with corporate manslaughter) and could also have an adverse effect on the medical profession.

Taking this advice into consideration, and after further consultation with its Members, the BMA has reached the decision not to petition for legislative changes to the law on GNM.

Future work to be undertaken by the BMA

The BMA will engage with stakeholders to address:

The irregular way in which the CPS approaches its investigations and prosecutions into GNM and the separate and often incoherent judiciary approaches.

The need for better quality expert reports through good practice guidance.

The BMA also believes the existing Crown Prosecution Service (‘CPS’) guidance should be further revised particularly in relation to early prosecutorial involvement in police investigations in medical cases and the roles and responsibilities of key offices including the Senior Coroner.

Legal test

GNM involves only the highest level of negligence. In considering the most recent case-law[iv], the legal test for GNM has the following five components:

i) The defendant owed the deceased a duty of care;
ii) The defendant negligently breached that duty of care;
iii) It was reasonably foreseeable, based on knowledge at the time of the breach, that the breach gave rise to a serious and obvious risk of death;
iv) The breach caused the death;
v) The circumstances of the breach were truly exceptionally bad so as to amount to gross negligence.

All five elements must be proven for an individual to be convicted of GNM.

Gross Negligence

The duty of care for both civil and criminal liability in negligence is focused on the act, rather than the actor. In other words, it considers the standard of care appropriate for a competent doctor undertaking a procedure or examination, rather than seeking to impose gradations of a duty of care based on the training or experience of the practitioner. It follows that a doctor will not be negligent if he had acted in accordance with a practice accepted as proper by a responsible body of medical opinion.

Whilst there is no requirement for the prosecution to prove subjective foresight of an obvious and serious risk of death on the part of a defendant, the bar that the prosecution must meet in proving the offence remains extremely high. For example, the need for an obvious and serious risk of death, rather than any lesser risk, has been thoroughly strengthened in recent cases such as *Honey Rose*[v], where it was underlined that the risk has to be objectively identifiable based on existing knowledge on the part of the defendant, rather than knowledge that could have been acquired through additional enquiry, however proper such enquiry would have been. Both in that case and in *Sellu*[vi] before it, the extraordinary degree of negligence that is necessary to amount to gross negligence has been repeatedly emphasised.

It must also be proved that the grossly negligent breach of duty was the cause of the death. The breach of duty must have been more than a minimal or negligible cause of death – it must have contributed significantly to the victim's death. A failure to act, beyond a point at which it can be concluded that intervention would not have saved the life, cannot establish causation. There is also no requirement for the jury to evaluate which competing cause of death was dominant.

The degree of negligence required was illustrated in the case of ***Misra***[vii] where it was said:

> '*…Mistakes, even very serious mistakes, and errors of judgment, even very serious errors of judgment, and the like, are nowhere near enough for a crime as serious as manslaughter to be committed*.'

As it is for the jury to decide whether negligence is gross, it is important that members of the jury are provided with the appropriate direction at an early stage in proceedings. The Criminal Practice Direction encourages the giving of written legal directions to the jury before the end of a trial in appropriate cases. Judges could be encouraged to provide written legal directions to the jury at the outset, rather than at a later stage in the trial.

Systematic failures

Systematic failings that provide the context for the actions of an individual may impact both in the determination of whether that individual's actions can be shown to be a cause of death, and as to whether any such actions can be characterised as gross. Systematic failures ought to represent

mitigation in relation to an individual being prosecuted for GNM and it is in the Counsel's experience that this is already the case.

Corporate manslaughter

Proving corporate manslaughter is a particularly difficult test. This is because the death must be shown to have been more than minimally caused by the way the hospital's activities were organised, and specifically the way they are organised by its senior management.

Furthermore, evidencing an audit trail of senior management hospital activities which led to a death in a hospital is generally very difficult to determine.

Increasing corporate manslaughter prosecutions may have the perverse effect of eroding the relationship between employer and employee that is currently mainly collaborative.

Involuntary culpable Homicide (Scotland)

The BMA asked Duncan Atkinson QC, to consider whether the equivalent offence of involuntary culpable homicide in Scotland could instruct how the offence of GNM could be developed in the England and Wales.

Culpable homicide is a common law offence (not defined in statute). Gordon's *Criminal Law* defines Culpable Homicide as:

> "*the causing of death unintentionally but either with a mens rea [guilty mind] which is regarded as sufficient to make the homicide culpable but not murderous, or in circumstances in which the law regards the causing of death as criminal even in the absence of any mens rea in relation to the death*"

However, this definition, also recognises that there may be circumstances where the defendant should be and can be found guilty even where the *mens rea* "*in relation to the death"* cannot be established.

Scottish Case law, however, explains that proving the *mens rea* is paramount in deciding a case of involuntary culpable homicide by addressing the key question:

> "*Did the perpetrator possess the necessary criminal intent at the time of the act?"*

This case law also explains that the criminal intent (*mens rea*) can be defined as:

> "*an utter disregard of what the consequences of the act in question may be so far as the public are concerned*" or "*recklessness so high as to involve an indifference to the consequences for the public generally*".[viii]

Therefore, while it appears to be possible to convict without the *mens rea* "in relation to the death", the Scottish case law authorities clearly state that in cases of involuntary culpable homicide establishing the *mens rea* is essential. So, any prosecution of a doctor for involuntary culpable homicide would appear to have to prove the *mens rea* in order to convict.

Conclusion

In considering the advice provided by Duncan Atkinson's QC, the BMA is of the understanding that introducing a similar requirement for *mens rea* for GNM would be highly unlikely to materially alter the considerations for the jury in most cases.

Moreover, it would not lead to greater certainty or more protection for the individual. This is because the same conduct that can be considered in GNM cases, to assess whether there has been a breach of the duty of care and/or the extent (grossness) of the negligence, would instead be held to determine

mens rea (the state of mind of the individual). Moreover, a judge would be no more likely to stop a case in the early stages for lack of evidence relating to *mens rea* because as with GNM they would consider that to be a matter for the jury.

In view of this advice, the BMA position is not to petition for legislative changes to the law on GNM. The BMA will, however, focus its efforts on:

- Addressing the inconsistencies in approaches in CPS investigations and prosecutions and the separate inconsistency in the way the judiciary approach cases.
- Petitioning for revisions to current CPS Guidance, particularly in relation to early prosecutorial involvement in police investigations in medical cases.

[i] https://www.bma.org.uk/collective-voice/committees/medico-legal-committee/medical-manslaughter
[ii] Ibid
[iii] Ibid
[iv] [2017] EWCA Crim 1168, at para.77
[v] [2017] EWCA Crim 1168
[vi] [2016] EWCA Crim 1716
[vii] [2005] 1 Cr. App. R. 21
[viii] TRANSCO Plc v. Her Majesty's Advocate [2004] ScotHC 57 (16 September 2004), per Lord Osborne at para. 4.

Ends 21 November 2019