

# Manslaughter – How Did We Get Here?

Dr Michael J Powers QC

*Clerksroom & ADR Chambers, Taunton*

A meeting of the Medico-Legal Society was held at The Medical Society of London, 11 Chandos Street, London W1, on Thursday, 13 January 2005. The President, Dr Neville Davis, MBE, was in the Chair.

**The President:** Good evening, ladies and gentlemen. I think we are in for another treat this evening. Standing on my left, Michael Powers is very clearly a man of many parts. He started off with a degree in biochemistry, then qualified at the Middlesex in 1972 and at that time practised as a junior doctor, principally in obstetrics, anaesthesia and intensive care, and then went on to be called to the Bar in 1979, when he did mostly criminal work, but then, as one would imagine, he leaned towards medical negligence, as it then was, now clinical negligence, of course, and has built up a considerable practice. I had dinner with Michael this evening and I asked him if there was any particular thing that he would like me to emphasise in my introduction to you. He gave some interesting responses. He is very interested in the scientific basis of evidence, and also the ethos of the two professions. Michael said quite clearly that, although he works both for claimants and defendants, he still regards his clients almost as patients and therefore has a duty of that type of care – it is an interesting concept. Michael, I would be very grateful if you would talk to us now on **Manslaughter – How Did We Get Here?** (Applause.)

**Dr Powers:** Mr President, thank you very much for your kind words of introduction. The 13th century depiction of Hippocrates administering some potion to a sick patient whilst his wife or assistant looks on with an exophthalmic stare of astonishment – as if to say, “Are you really going to administer that medicine to this poor fellow?” – reminds of how the medical profession was seen in 500–400 BC:

“Medicine is the most distinguished of all the arts, but through the ignorance of those who practise it and those who casually judge such practitioners it is now of all the arts by far the least esteemed.”

Over the centuries many have sought to mock the medical profession, whether the purpose be to challenge the position in which physicians have held themselves, or to remind us of our personal frailties. A 17th century Dutch painter depicted a quack doctor trying to persuade his gullible audience that his potions work. To reinforce that message the quack doctor is shown wearing the academic robes that were so often worn at that time by physicians. He *looks* distinguished and trustworthy.

The public were faced with problems from real physicians too. Another 17th century Dutch painting of a doctor shows the professional interest in the radial pulse whilst emphasising his greater interest in the maid that is holding the urine. (Laughter.)

I have to say that a number of the illustrations I am showing you come from a magnificent book by Professor Alan Emery and Marcia, his wife. It is published by the Royal Society of Medicine Press and I would earnestly suggest that you have a look at it, or, if not, use it as a present. It was given to me as a present and I am extremely grateful for it.

By the early 18th Century, medicine had become almost a mockery. This has been illustrated in a number of contemporary paintings. This one by Thomas Rowlandson is really taking off the medical profession in the social environment. You can see a terribly rich man here, obviously ill with gout, attended by numerous physicians, some feeling the pulse, another one feeling the heart beat. Still others threaten medications whilst some give advice of one kind or another.

It is not surprising really that Matthew Arnold, writing in a poem in 1867 called *A Wish*, said this:

“Nor bring, to see me cease to live,

Some doctor full of phrase and fame,  
To shake his sapient head and give  
The ill he cannot cure a name.”

In the course of my research for a present day negligence action I became aware that towards the latter part of the 19th century, largely because of the use of chloroform, physicians became a lot more keen to become instrumental. In the treatment of obstetric patients of those having domiciliary visits up to 70% were being administered chloroform for child birth. This level of medical intervention was associated with a three-fold higher maternal fatality rate. Thus the professional classes and the salaried classes, who could afford to have doctors attend them, were much worse off than the working classes, who were left to the non-interventional midwives and charities.

But again towards the end of the 19th century we began to see medical manslaughter cases emerging. A distinction was drawn between individuals wanting to bring civil claims against one another for “mistakes” and more serious professional conduct. The law illustrated this thus: Supposing a man performing a surgical operation, whether from losing his head or forgetfulness, or some other reason, omitted to do something he ought to have done, or did something he ought not to have done, in such a case there would be negligence, but if it was only the kind of forgetfulness which is common to everybody, or if there was a slight want of skill, any injury which resulted might furnish a ground for claiming civil damages, but it would be wrong to proceed against such a man criminally in respect of such an injury. And a very stark example, but if a surgeon was engaged in attending a woman during her confinement and went to the engagement drunk and through his drunkenness neglected his duty and the woman’s life was in consequence sacrificed, there would be culpable negligence of a grave kind – it is not given to everyone to be a skilful surgeon, but it is given to everyone to keep sober when such a duty has to be performed. (Laughter.) Well, that was the start of it, I am afraid. Now you can be sober and still be done for manslaughter.

Tonight our President told me that he was born at Charing Cross Hospital in 1925. This was just a year after a lady called Mary Jane Harding had a child delivered at home a few miles further east in Deptford. She was the wife of a labourer. She and her husband lived in poverty in a tenement. The attending midwife encountered difficulties in the delivery and she called a Registered Medical Practitioner called Dr Percy Bateman to assist. Dr Bateman administered chloroform and for an hour he used various instruments trying to deliver the baby. Evidently it was a breech presentation. After an hour of struggling he attempted to do an internal version. I don’t think these attempts are done any more - probably in part because of what is known of Percy Bateman’s activities. Anyway, he continued again for about another hour and eventually delivered the baby dead. He took the view that probably the woman wouldn’t live very long either – at least he was right in that respect – but he wouldn’t transfer her to the infirmary despite the requests of both the husband and the midwife. In consequence of her death, a charge of manslaughter was brought against him.

At the post-mortem, the lady was found to have a ruptured bladder, a colon completely crushed against the sacral promontory, a ruptured rectum and virtually no uterus – this had been extracted with the dead baby and the placenta. It was a surprise really that she lived as long a week. When she did go to the infirmary on the fifth day, they couldn’t operate on her and she died a couple of days after that.

Percy Bateman was charged with these three charges – causing internal ruptures in performing the version operation, removing part of the uterus and delay in sending the patient to the infirmary. He was convicted. In those days doctors didn’t like being convicted of manslaughter any more than they do now. Whether by the MDU/MPS or otherwise I know not but he was able to instruct on the appeal Norman Birkett KC for the appeal. Norman Birkett had only been at the Bar for twelve years as a King’s Counsel. Sir Norman Birkett, of course, as many of you will know, went on years later, 15 years later or so, to become one of the judges at the Nuremberg trials. He was leading Sir Edward Marshall-Hall, another very great advocate and also a King’s Counsel – both of the same chambers. The appeal was

before the Lord Chief Justice, Lord Hewart. Lord Hewart was the man who is known for that statement that “justice not only has to be done, it has to be seen to be done”, and he explored the various aspects of the law concerning manslaughter, and he came out with this seminal statement:

“The Prosecution must satisfy the jury that the negligence 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.”

The real problem with the *Bateman* case was that the judge had messed it up at the trial. He had failed to withdraw from the jury the first of the charges on which (surprisingly) there was no evidence. Only two charges should have remained on the Indictment which went to the jury, but because the jury had all three and they collectively convicted upon all three, the Court of Criminal Appeal were persuaded that it was not safe to conclude that the jury hadn't convicted because of the first charge which should never have been before them. So Percy Bateman, who was sentenced to the standard six months suspended, had his sentence and conviction quashed.

The Bateman case was really the start of the sequence of cases which have built up since then. In the years between 1925 and 1969 there were only two cases that I have been able to find and others have been able to find where doctors were convicted of manslaughter, and then in each of the decades after there have been about two, until the last decade of the last century, 1990 to 1999, when there were ten, and then in the following year there were 13, and so we are seeing a gradual increase in the number of prosecutions of doctors.

Many of you will have heard about the 1990 case of Malcolm Savage, a 16-year old with leukaemia, who was being seen regularly at Peterborough General Hospital and treated with cytotoxic drugs, methotrexate intrathecally and vincristine intravenously. He was under the care of a Consultant Haematologist called Dr Fairburn, who didn't have any medical staff himself, but who wrote up the drugs on the day before he was to be admitted, on 27 February 1990. The drugs were made up in the pharmacy and they were appropriately labelled in the two syringes, each labelled, and they were put into a red box which was appropriately labelled. Fine so far but, because he didn't have his own staff, Dr Fairburn had to rely upon the staff of another consultant: the House Officer, who was what seems to have been a Senior House Officer, a man called Sullman. Dr Sullman was told that Malcolm Savage was going to come in for his injection on the day before. When the young lad came in with his mother on the 28th he was first presented to the pre-registration House Officer, called Prentice. Now Dr Prentice was very fearful about his ability to do a lumbar puncture, because he had never done one, so he spoke to the Registrar, Dr Chua, and the Registrar said, “Well, if you are worried about doing it, get Sullman to supervise you.” Dr Sullman, who readily took on this responsibility, so it seems, had only ever done one lumbar puncture himself, and that one had failed. Nevertheless on the day he came along and Dr Prentice, the pre-registration House Officer, scrubbed up. The drugs were produced in the red box and put on to a lumbar puncture trolley. This was not the usual cytotoxic trolley, which would have had some extra cards on, and so on. Two junior nurses came into the room who had never seen the procedure before. The experienced nurse who usually supervised and helped with these injections decided simply that she would leave them to it as there were two doctors as well as two junior nurses present. Presumably with some excitement (and doubtlessly a sense of relief), Dr Prentice, the pre-registration House Officer, got the spinal needle just into the CSF. Some CSF came out. Dr Sullman would also have been relieved and at that moment Dr Prentice asked for the drugs to be passed. Dr Sullman passes across the drug and Dr Prentice connects it. At the same time Dr Sullman is saying to Dr Prentice (because Sullman wasn't scrubbed up) “Don't forget, it's not sterile now I am passing it to you”. The young Pre-Registration House Officer may have been a bit flustered by that. It is very exciting, he's taking the syringe, “I'm sterile, yes”, and in the drug goes. Unfortunately, it is not methotrexate, it is vincristine. Nothing could be done to save this poor lad, who dies. Both doctors were charged with manslaughter and both of them were convicted.

There have probably been 20 or so fatalities by doctors who have put vincristine into the cerebrospinal fluid.

In this case the judge this told the jury:

“You have to be satisfied that the risk would have been obvious to any ordinary prudent doctor of the experience and knowledge of the status of the defendant, and, lastly, you have got to be satisfied that the defendant gave no thought to the possibility of there being any risk.”

It is very much a sort of “That is the scope of the mental element that you have to have in mind, members of the jury, when you decide whether or not to convict”, and of course, as I say, they convicted.

In 1987 I was instructed to go to the Croydon Coroner’s Court to appear before the Croydon Coroner. (Laughter.) Oh, it wasn’t *this* charming gentleman, an ex-President of this Society (Dr Roy Palmer), that I appeared in front of. It was a very brilliant (now deceased) lady then known by most members of the Bar as *Mad Mary McHugh*. She was dubbed by Lord Justice Watkins as a “mistress of discourtesy” in one judgment and she was extraordinarily tough on any counsel or solicitor who appeared in front of her. I was there to represent the family of a man who had died in the course of surgery. His name was Loveland. He had come in as an emergency to the Mayday Hospital with a visual problem and he had been found to have a detached retina in his right eye, and it was decided that he should have an operation on the following Sunday morning. A very experienced junior anaesthetist, Dr Saad, was assisted by an ODA. The patient was paralysed and ventilated and surgery got underway. Save for the eye and his left hand the patient was completely covered with drapes. There were monitors on the ventilator, a blood pressure machine. An ECG was running. Then Dr Saad was called away to do an emergency Caesarean section as he had the requisite experience in emergency Caesarean section anaesthesia. The ODA left the eye theatre first. Dr Saad waited for his replacement, a Dr Adomako, to come and take over.

Dr Adomako was qualified in Russia, in Rostov. He had been in this country at the time for about 15 years. He was described by a subsequent court as a “perennial locum”. He had done six months in anaesthesia in numerous different hospitals and at the same time was doubling up as locum in places like Mayday. Thirty minutes after taking over, Mr Loveland had a cardiac arrest. It seems that there was a disconnection in the anaesthetic circuitry which went unnoticed. For those that have experience of anaesthetics, when surgeons are operating in the head and neck area and leaning on all the tubes, the anaesthetists are usually extraordinarily vigilant to make sure all the connections stay in place and that there is good monitoring and sufficient alarms for the early detection of a disconnection. Dr Adomako didn’t pick up the disconnection. He was convicted of manslaughter.

Four cases then came before the Court of Appeal, the case, in particular, of *Sullman and Prentice*, which I have just told you about with the vincristine, *Adomako* and another case which involved an electrician, and what had happened is that at the courts of first instance the judges had used different tests. In *Sullman and Prentice* Mr Justice Owen incorporated this concept of *recklessness* in to the test. He did not use the original Lord Hewart definition of *gross negligence*. Because of the differing approaches which had been adopted the Court of Appeal laid down a number of elements of this offence.

These are (i) *the existence of a duty* – that is usually a duty of care – that of a professional person, whether he be an electrician or anybody that has got a responsibility towards someone else to look after them, (ii) *a breach of that duty causing death* and (iii) *gross negligence* which the jury considers justifies a conviction. The court gave some illustrations given of that state of mind. *Indifference to an obvious risk* – you don’t really mind whether it is there or not. *Actual foresight of the risk* – “Okay, it’s true we’ve got a risk. Nevertheless, let’s go on and do it.” Or *an appreciation of a risk*, trying to avoid it but making such a hash of it, such a high degree of negligence associated with your attempts to avoid the risk that the jury believe it justifies a conviction. Finally, *inattention*. This incorporates a concept of objectiveness. In other words, you don’t really have to have too much regard to what is going through the doctor’s mind. If it *should* have gone through his mind – bearing in mind the skills that he had

– and he should have addressed them, but he didn't, then the jury may find he had the requisite degree of mental element which would enable a jury to convict him.

The trial judge in Adomako's case had told the jury the right thing, and so his conviction was upheld – he got the standard thing, you know, six months suspended – whereas Sullman and Prentice had their convictions quashed because they were unsafe. As a consequence of Adomako's conviction, the matter went to the House of Lords, where the issue was clarified in a very important respect by Lord Mackay:

“The jury has 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 could be judged criminal. The essence of the matter, which is supremely a jury question [and still is, as will be considered in this talk] 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.”

You can see now the importance of the incorporation of *this* concept, because when you incorporate *this* you have to think of poor Prentice. He had never done one of these things before. He genuinely believed that he was being supervised not only in respect of the injection into the CSF with the spinal needle but that he was being supervised in respect of the drugs, and Sullman thought he was only there to supervise getting the needle into the CSF and he wasn't supervising the drugs, and the consultant who had written them up had staff that weren't trained by him. There was no supervision going on here and one can see how that terrible tragedy with Malcolm Savage arose and how, had the jury been permitted to take into account all the administrative/organisational reasons, all the other pressures that were upon these doctors, although plainly they were at fault, they may very well not have convicted.

Since that time, in October of last year, there has been just one more challenge although *Adomako* remains the law. In this challenge, a young man had a patella tendon injury, which was repaired. It became infected, and the two junior doctors that were looking after him on different shifts essentially disregarded all the signs of a massively developing infection. He wasn't treated and the patient developed toxic shock syndrome and died. The two doctors, Mizrah and Shrivastava, were both convicted. In the Court of Appeal there was an interesting argument largely around the lines of “Well, how can you have certainty if it is the jury that are always going to decide whether or not a crime has been committed?” and “There is an obligation under the Human Rights Act to have certainty to know what sort of offence it is you are likely to commit and what is going to happen to you.” The Court of Appeal very simply said “The common law has always incorporated certainty in this offence. The Human Rights Act has added absolutely nothing to it. Of course there is certainty.” Lord Justice Judge cleverly got round this by saying that “the question for the jury is not whether the defendant's negligence was gross and whether, additionally, it was a crime” – in other words; the jury decided the crime – “but a question of whether his behaviour was grossly negligent and consequently a crime”.

A subtle play on words, but it meant that the certainty is there, the crime is there without the jury deciding it. They simply look at all the facts and all the circumstances and they say “In all the facts and circumstances, is this gross negligence a crime in this case?” The jury does not decide what the crime is – simply whether it has been committed.

It seems that many of the medical profession are concerned that doctors are being prosecuted at the least excuse. We should bear in mind that what society is doing here is what we as a medical profession want to be able to do. We have got to have an element of control over excessively bad behaviour. We have to accept society has the right to control bad professional care. It is essential if we are to be a responsible profession wanting to see our professionalism properly respected.

Just one or two pictures before I finish, just to help us remember. I think *this* is a beautiful picture of a physician listening to the little girl's doll's heart, “Doctor and Doll”, a picture by Norman Rockwell in 1929, and doesn't it tell us so much? Doesn't it really tell us how caring this doctor is? What a wonderfully warm picture. He is putting on a real look of earnest seriousness in listening over the heart of this little girl's doll. She is quite convinced that he is

being serious about it. You can imagine the amount of rapport that is being built up by that type of relationship and how well that image reflects upon our profession.

So too, and very importantly, *this* picture, because in the end 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. *This* wonderful picture of a doctor, by Sir Luke Fields in 1891, spending his time, anxious, as a professional person, about the nature of this child's condition and how sick the child is or what he can do to try and help this child. It is impossible from a picture like that to imagine that a jury would convict him if he were to make a mistake. The cases where we have seen convictions are cases which stick out like a barn door: how could a doctor possibly have neglected such an important function as checking a drug like that, or fail to attend a child that he had been told was sick so many times on the telephone?

Interestingly, *this* picture, too. It took me some time to realise that the doctor is probably actually obstructing the pulse to this wrist, it having taken the same shade as the rest of nude patient. (Laughter.) The other hand seems to be the ordinary colour. Interestingly, it is a painting, can you believe, by Pablo Picasso in 1897, before he went on to his Cubist movement, and I think it reflected to me the way in which a great artist – and obviously he is a great artist – it helps me to appreciate it a great deal more when he produces a work like *that*. This is a great artist and I can understand what is happening in this picture. Maybe I am not sufficiently attuned to the finesse of more modern art. But this picture also demonstrates to me how a man of his ability can change and develop in the way in which he views his particular professionalism, and I wondered how Hippocrates would now wish to make that statement, and, with apologies to him, I suggest that this is really what he should now be saying:

“Medicine is the most distinguished of all sciences, and through the wisdom of those who practise it and of those who carefully judge such practitioners it is now of all the sciences by far the most esteemed.”

I leave you with a picture, painted by Norman Rockwell on a visit to a surgery in the year I was born, 1947. It conveys a phenomenal degree of warmth and attention, with parents dutifully respecting what this doctor is saying – even the baby is learning – and the light behind the doctor's head, acts as the halo of their attention.

Thank you all very much. (Applause.)

## Discussion

The President: Thank you very much, Michael, for a very interesting and stimulating talk. I must say, being a doctor listening to this, it makes you feel good, doesn't it? And I was very interested to see you talking about *your profession* when you mentioned medicine – it was quite touching. Now, would you take questions?

**Dr Powers:** Yes.

**The President:** Those of you who would like to ask questions, please would you be kind enough just to say your name and your discipline, and we will go ahead.

**Dr Roy Palmer:** Dr Powers, thank you very much for a fascinating address. I declare an interest, in that, in a previous existence, I was Medical Director of the Medical Protection Society and in that capacity assisted certainly two doctors with medical manslaughter cases. One was a Senior House Officer in South Wales many years ago (it was in the 1970s) – who, like the case you illustrated, was not the regular oncology Senior House Officer – the regular oncology team were having their annual bash – and she was induced to give a midnight dose of cytotoxic agent to a boy of four. She muddled up what was intended as an intravenous dose and gave it intrathecally through a line. The other case that I was privileged to assist in was the *Dr Adomako* case, and I wonder whether you would care to respond to something I felt about that case. First, Dr Adomako, as you say, qualified in, I think it was, the Patrice Lumumba Memorial Hospital in Moscow, and he was not an English national and, as you say, he was a peripatetic locum, and Drs Sullman and Prentice were home-grown products, and

one did just wonder whether that played its part in the decision of the jury. But also would you perhaps agree that he was in a sense a legal victim, in that Dr Adomako had the misfortune to be tried by a High Court judge who applied one particular test? As you have indicated, there were two tests in different divisions of the Court of Appeal, one the *gross negligence* test, the other the *recklessness* test. In the *Sullman and Prentice* case, their judge picked one and was ruled to have been incorrect. Dr Adomako's judge, it was subsequently said, picked the correct test, and so he got convicted. I have argued indeed in a past edition of the Journal of this Society – some may have read it – that, as it were, the enormity of the magnitude of the medical error was common in both cases, and it is not for me to say whether or not the one or the other was rightly convicted or acquitted, but I do make the point that the nature of the clinical error in the one case was no worse and no better than the nature of the clinical error in the other case, particularly since, as you said, Dr Adomako took over half-way through a case; he was not involved, he didn't set up the circuit; and I just have a lingering worry about the security of the conviction in Dr Adomako's case. And the other point I am just going to finish with is something you didn't illustrate in your slides, that Lord Mackay, who was the only judge in a five-man appellate court in the House of Lords, the only judge to give an opinion (the others were all nods), did make the point, did he not, that to some extent his argument was circuitous, and the worry one has is that, in applying that test, there is a real risk that unless the jury is extremely carefully directed by the trial judge they will muddle up the enormity of the consequence with the enormity of the error giving rise to the consequence.

**Dr Powers:** Well, as far as the lottery is concerned, the simple answer is that if you know anyone who wants to become a grossly negligent practitioner, then make sure he doesn't get a terribly competent judge, because if the judge misdirects the jury, then even if you are convicted you will have your conviction quashed and you are not likely to face another trial. As to whether Adomako was properly convicted, it certainly seems as though the negligence direction given to the jury was effectively a straight *gross negligence/carelessness* direction. I think the word "reckless" was mentioned, but the principal distinction, of course, between the two channels is that gross negligence is something which does admit circumstances, although they weren't to be defined until Lord Mackay's Speech, when he specifically set out "in all the circumstances". It is essentially left up to the jury. They can incorporate the wider impression as to whether the fault amounted to the crime. I accept the circularity argument but it is obviously one that has fallen away now; I cannot imagine it is going to go any further. In the end, a crime is that which deserves punishment. It can't be defined and isn't defined any more than that and a jury has to decide whether in this case the behaviour is so bad that that line in fact has been crossed. It isn't a jury deciding whether or not there *is a* crime, but rather whether or not *the* crime has been committed. The jury has to decide whether the line been crossed in a particular case. I don't really think that we could break the circuit any more effectively than by those magical words which Lord Justice Judge used in the *Mizrah* case very recently.

**Dr Alveyn:** Tony Alveyn; I am a physician. It seems to me that in some of these manslaughter cases the fault actually is organisational and that certainly in the *Prentice* case these guys should never have been attempting to do what they seem to have done and they were put in a position where whatever they did was likely to be wrong. So what would your advice be to people who find themselves in the same situation where they are called upon to administer a drug or undertake a procedure that they know they are not trained to do, bearing in mind that the Chief Executive will almost certainly suspend them if they don't go ahead?

**Dr Powers:** We have to bear in mind that both *Sullman* and *Prentice* were negligent. I don't believe that that was really challenged before the jury. It was probably admitted that there was a breach of the duty of care which they owed to the patient but that it didn't amount to a crime in all the circumstances. The short answer to that is that doctors have to be more careful, as we all do in the exercise of our respective professions. As to whether it amounted to a crime, well, of course it was the organisation that was at fault. Dr *Prentice* had said on quite a number of occasions, he was very worried about going ahead and doing this. He very, very much wanted to be looked after, but he wasn't looked after, either by *Sullman* or by

Chua. He was just put on the spot. I would like to think that most professionals, legal or medical, would be sufficiently sensitive to the times when you can push your junior staff to do something where they just need a little boost and they can effectively do it and the times when they are actually saying to you (almost a cry for help), “Don’t put me there. I am not up to it yet.”

**Dr Alveyn:** So what’s your advice to Prentice?

**Dr Powers:** Well, Dr Prentice has been through the hoop. He will have learnt his lesson. I don’t think any of us should ever take on anything in an area which is not within our expertise or ability. I would say, “Look, I haven’t done one of these things before.” Of course there were other factors there. That is why I think most people have enormous sympathy with those two doctors that just happened through sheer bad luck to be in a situation which, had it been another situation – if the Staff Nurse had been present, for example, she would have probably checked the drugs being passed across, but she wasn’t, and the trolley wasn’t properly laid out, and we don’t know that the drugs sheet was there either. There were so many factors that came together. This poor 16-year old child was killed through the incompetence of the system and through two, at least, negligent doctors.

**Dr Alveyn:** But the system doesn’t suffer, does it?

**Dr Powers:** It doesn’t. We probably will see corporate manslaughter before long. Whether that will make any difference we don’t know. The Chief Executive will just have to find some more money, and that will be it. Whether it will really impact or not we will have to see when we get that legislation.

**The President:** Diana.

**Mrs Brahams:** Diana Brahams. Thank you very much, Michael, for your talk; it was very interesting. I think you have only answered part of your brief really, because you are saying “How did we get there?”, and I was thinking, well, how did we get there with such a great increase in numbers of doctors being tried for manslaughter? I mean, you were at pains to point out how the numbers have increased, and I would like to have your view on why this increase has happened?

**Dr Powers:** You have seen that there has been really quite a rapid acceleration. We saw the *Docherty* case in 1867, I think it was, *Bateman* in 1925, a few cases after it which really didn’t go anywhere, until the *Sullman and Prentice* and *Adomako* cases came along in the early 1990s. Once the law was clarified, it was very much easier to see whether or not you could put these cases before juries. So I think that was part of it. There has also been, of course, a pretty sizeable change in the way in which the public view this. Once upon a time we would take anything from our doctors. We would assume that they weren’t murdering us. We would assume they were acting not only in good faith, but competently. We wouldn’t want to see them convicted of a criminal offence, and – I don’t know whether Roy will bear this out – there has probably been a change over the years in that doctors are more readily convicted. Certainly prosecuting authorities seem to be more prepared to follow through on complaints. They may even feel there is an obligation to do so because, if they don’t, they are judicially reviewed.

**Mrs Brahams:** The research is going hand-in-hand with the increasing numbers of cases brought against doctors for negligence, but effectively there were very few cases for negligence at one time, so there were even fewer cases for manslaughter, so perhaps...

**Dr Powers:** Yes, it may well be true, but each of us will know, both sides of the profession, that there are many occasions where we fall down. I mean, I very much doubt if anyone in this room has gone through their careers without making a mistake. Usually it has been picked up by them or by somebody else or recovered in time. Sometimes it is not too bad a mistake and easier to sweep away. But there are, on the other hand, a lot of cases of patients being injured by treatment. 10,000 people every year in the NHS are apparently injured as a consequence of avoidable medical accidents. We don’t know what the accuracy of these figures is, but we certainly know that a large number of people are injured by doctors and nurses and other health professionals. An increasing number of those I think we can reasonably expect will either be brought through civil litigation or through criminal litigation

as that present threshold is reached. I think it is unavoidable. What we have to do is cut down on negligence.

**Dr Josse:** Edward Josse, physician. The first case of medical manslaughter of which I was aware was when I was a Senior House Officer at Chase Farm Hospital in 1957/58, and there an anaesthetist called Gray who sniffed the gases and, in doing so with a child who was having a hernia repair, the surgeon didn't notice that the oxygen had run out and the child was blue. The intern technician noted it and changed the cylinder, but the child by then had died, and Gray was convicted of manslaughter and served one year. Now the point of the story, which is totally different to all the cases you have mentioned, is that the other staff knew about this. The surgeons knew that this anaesthetist sniffed the cyclopropane, or whatever anaesthetic agent, nitrous oxide, and became insensible at times. Now it was because of that the "Three Wise Men" situation developed in hospitals so that there could be some regard given to such known behaviours of doctors. I don't think the system has been a total success in actual fact, but it seems to me that that is a much more culpable situation where your fellows know that there is something potentially lethal, be it an alcoholic doctor, or whatever.

**Dr Powers:** Yes. I know that Kevin Dalton is sat at the back and he was telling me over dinner tonight that he now sits as Chairman of the Professional Conduct Committee, having spent years beforehand screening cases. I would be interested to know from him about the professional obligation upon us as doctors to protect the public by bringing these cases to the attention of the relevant authorities. Kevin, do you want to say something about that, because we would be interested to know how well that is operating?

**Dr Dalton:** That is quite right. It certainly used to be that if one did bring it to the notice of the hospital authorities that in itself could be considered serious professional misconduct. How often it happens I am not sure, but certainly, from one's own practice, one is now more and more aware that people will go and report much more readily.

**Dr Powers:** The difficulty, it seems to me, is that it needs to be done in a totally non-acrimonious way. It needs to be done on the basis that:

"I have a direct responsibility to the public and to my profession. I may be wrong, but this needs investigating, and I won't be doing my best by the people I serve in my profession if I do not bring this quackery/bad practice" – (whatever it is) – "abuse of the system to the attention of those that can put it right."

**Dr Peter Dean:** Thank you for a fascinating presentation. I am a forensic medical examiner and coroner. I have to say there are more and more of these cases getting to the criminal courts, indeed more getting to the civil courts as well. Quite a few of them wind up before Coroners' Courts, particularly in the area of deaths in custody. As the Human Rights Act becomes more a part of European law, the boundary is pushed and Article 2 is quoted again and again in deaths in custody cases. One is now beginning to see a trend for Article 2 to be invoked on the grounds that, if a patient dies in a NHS hospital, they are in the hands of the state, and of course there has been some case law on that, but I wondered what your thoughts were on the use of Article 2 at inquests in cases where patients die, say, in a NHS hospital, for example, at the hands of a medical practitioner there.

**Dr Powers:** Yes. It is almost a planted question. I have an interest in this matter having just lost the particular case on behalf of the family that you are referring to in the Divisional Court: *Goodson*. It is going to the Court of Appeal with the leave of the judge, and, without spending a long time unfolding the way in which I see this, it certainly seems to be that the judge that heard this in the Divisional Court took the view that Article 2 did apply in general terms but that the system of law that we have in this country, through its various channels, is able to discharge an effective inquiry in the sort of cases where people die in hospital, where the state may potentially bear responsibility. Now that meant, as far as he was concerned, in this *Goodson* case, that we couldn't criticise (and so he found) the Coroner for not regarding this as an Article 2 death and treating it as such. His view was that the relatives could use the system of law through its various channels, civil and criminal. Although it would not be for years that it could be seen that the state had discharged its Article 2 duty to have in place a proper system of investigation of deaths in hospital. Only at the end could the High Court

pass judgment upon this. The argument which we are advancing is simply that, if this is effectively an Article 2 case, why not let the Coroner treat it as an Article 2 case and get rid of it, discharge it at that level. The House of Lords, as you know, in the *Middleton* case has said that coroners should regard all the Article 2 cases as Article 2 investigations and coroners should be responsible for them, unless there is a full-blown criminal trial or they are otherwise informed there will be an Article 2 inquiry. We know at the moment that the *Middleton* case Mr Justice Keith is conducting an inquiry into the death of Mubarak in the Feltham Young Offenders Institution. It was listed for three months; the costs provisionally were £3 million pounds; but it seems that is going to be nowhere near enough money. Notwithstanding the racial issues this death is one which could, and perhaps should, have been dealt with at the Inquest level. Maybe a High Court judge sitting as coroner, or a very experienced coroner assisted by an amicus, should have held the inquest. The irony is that the death was pre-Human Rights Act. Undoubtedly there are other factors at play now justifying such a large expenditure on this inquiry.

**Mr Davies:** John Verdin Davies, a retired lawyer. Dr Powers has given us a masterly summary, I think, of the present state of the law on the culpable negligence of an individual named practitioner. I would welcome some sort of further observations on the idea of corporate manslaughter. Should it ever be applied (and I hope the idea is not too horrific) to the kind of situation in which a medical team, or perhaps an unidentified member of that team, has made an error of sufficient culpable seriousness to justify criminal negligence against them?

**Dr Powers:** Yes. Thank you very much for your remarks and for your question. My answer is simply yes, it must be so. Where the package of care has been grossly negligent worthy of a criminal punishment, but each of the components in the chain has got a reasonable excuse, it still leaves the public with the understandable belief that the system is not good enough and a sense of injustice remains if no one is called to account. It not only applies to the medical profession. It applies to Chief Executives and Directors of railway boards, and so on, and other circumstances where, through the inability to identify a single individual that can represent the mind of the company or a single individual that is responsible, no convictions are ever brought or ever brought successfully. There has to be a law of corporate manslaughter.

**Ms Lynch:** Selena Lynch; I am a coroner. I would like to try and give one answer to a question that you have posed and also to ask a question of my own. You asked why coroners shouldn't be allowed to conduct Article 2 cases in cases of medical negligence. I think one answer is that our country would then spend more money investigating death than in treating the living. But that is only perhaps one answer. The question I would like to ask you goes back to medical manslaughter, and, as I am only a lawyer, I need you to explain this if you can. Negligence is not a crime, and so it seems to me that juries are being required to decide what the crime is, no matter what the judges in *Mizrah* might say, and until juries are required to give reasons for their verdicts the risk of prejudice is ever present in these medical cases, where there is so much emotion and the potential for so much prejudice. If we are going to start criminalising professional mistakes, be they by doctors or lawyers, then a clearer statement of the law is surely required.

**Dr Powers:** To deal with your first point, I think the answer to that is that the coronial service, as you know, actually costs this country very little indeed; in fact, most coroners complain continuously about how inadequate the resources are and how they will never be adequate to meet any proposed revisions in the Coroner Service. However many millions are involved, it is nothing like the amount of money that is spent on health in this country. Not a fraction of it. Probably less than 0.1%. In the end the public have to take a view on whether more effective inquiries into hospital deaths is desirable and cost effective. When you look at all the knock-on costs and consequences it may well be cost effective to spend more money on such inquiries if lessons can be learned. I see no difficulty at all in properly having inquiries at a coroner's level and avoiding all the unnecessary litigation, anguish, and so on, which follows when litigants then go off and use other channels. So far as the other matter is concerned, I think there is an element with respect to circularity within your own argument.

There is a tendency to say “Criminalise mistakes”, which isn’t the right way of looking at it. The way of looking at it is that some mistakes are criminal. It is not criminalising mistakes, it is just that some of them are so bad they are in fact criminal mistakes, just as if you were to get in a motor car and drive at high speed having drunk lots of alcohol. That is criminal behaviour, just as it would be now for any doctor to go away and take a syringe, not knowing what is in it, and inject it into somebody’s spine. That would be criminal behaviour. It is not a mistake being criminalised. As to the certainty, well, we have discussed that. I appreciate the difficulties, but in the end the jury have got to decide whether this line is crossed or not. As every case differs, you can never really know in advance when that line will be crossed. We can easily see whether or not someone has failed to measure up to the general standards. That is perfectly easy but how far removed from that you have to be before the jury say “This is really, really bad” is another matter. As to juries giving reasons – well, heaven forbid. We were all terrified when magistrates began to give reasons. I think they’ve had lots of training and are probably very good at giving reasons now, just as judges have to be very good at giving reasons, but I can’t imagine for a moment that we are going to have juries giving reasons. If juries give reasons it would probably be that all the doctors would be convicted and all the other defendants would be let off.

**Dr Mansell:** Martin Mansell; I am a nephrologist. Bearing in mind your recent answer to “How Did We Get Here?”, I imagine that if I was to try and draw a direct parallel between the increase in the number of unfilled community paediatrician posts that have responsibility for child protection and the activities of our legal colleagues – and I was going to excuse you from that, but I am not sure that I should – but if I were to try and draw that connection, I imagine you would think I am being unreasonably paranoid.

**Dr Powers:** We know that a problem has existed in respect of experts. It is a problem which I now see only in civil work, and it is bad enough there. Hopefully it is getting better as a consequence of the activities of people like your President here. Indeed in *The Times* today there was an article by one of the leader writers on the difficulties of providing expert experts in criminal trials. I think the answer has to be that there needs to be some means of training. Even very distinguished medical men and women need properly to understand what their responsibilities are in giving expert evidence. They should not side with either the prosecution or the defence. Their object is to help the court and the jury and they need proper disciplined training to do this. If they don’t get it, or if we go on with our system, there will be people who will find themselves facing the difficulties that Prof. Sir Roy Meadow is facing at the moment. Some will back away from giving evidence. They will say “It’s too dangerous and we don’t want to do it”. So I think the only way to ensure that that really doesn’t happen is to have a proper system whereby experts, particularly in criminal cases, are effectively qualified to give evidence. It is like teaching: you may be a brilliant physician and you may be a hopeless teacher; you may be a very good teacher and a hopeless physician; you may be a brilliant expert at persuading people and yet get it all wrong, because you are no good. An expert has both to be a good doctor and a good expert opinion. He/she must be able to justify logically the opinion being expressed and to do so to support that opinion for its own sake rather than that of the party instructing.

**Mr Samuels:** Alec Samuels, lawyer. On the *Adomako* issues, I don’t find gross negligence a very helpful concept, I have to say. It does seem to me, if you are talking about a crime, you have to think about intentional or reckless infliction of harm, and that means basically that you are morally blameworthy or morally culpable. That seems to me the test, and that is a test I think that a jury would hopefully understand, and when you look at the *Adomako* case, as I understand it, the several issues would be: Was he taking on a task beyond the competence that he knew he had? Was he morally at fault when he didn’t notice the disconnection? Was he morally at fault when he misread the signs in the patient? Was he morally at fault when he got into a panic? Was he anything more than stupid, incompetent or [as they said in the case] abysmal? Did he cross the threshold so that he could properly be said by the jury to be morally blameworthy, morally culpable for what he did?

**Dr Powers:** Yes, I fully understand the point. It is a very sound point. As far as the law goes, as you know very well, they have got round this by saying, “Yes, all criminal offences,

except those strict statutory ones, basically require a mental element in them, common law offences.” Manslaughter plainly does, and then it is obvious you have a mental element if you intend to do something and out of anger, or whatever it is, you kill somebody, and you have it reduced to manslaughter, or you are just reckless, in the way in which generally we understand that term, you couldn’t care less what you are doing. But when it comes to negligence, of course, it is the absence of a state of mind which is the problem here. It is not having the state of mind that makes you aware, and indeed the present state of the law injects the element of objectivity into it; in other words, it is the state of mind which you should have had if you had been properly doing this as a professional; it is imputed to you; and of course it is quite difficult for us to see this when it comes round to doctors. I didn’t unfold the circumstances at the time or the reasons of the *Holloway* case, the electrician who has got all the wiring wrong and when people are being zapped here and knocked out there and zapped here, you know, he just continues in the same incompetent way until somebody finally electrocutes themselves in the kitchen when they’ve got nothing on their feet and there’s water on the floor and they touch a tap. That we don’t have any difficulty in saying “Good heavens above, who’d have an electrician like that? How grossly negligent that was. That must be criminal.” When it comes round to doctors, somehow we seem to feel that they can be excused for not realising that they cannot inject drugs into the spine without checking what they are. But I am afraid that juries don’t excuse them; they say “This is just one too far. This should never, ever have happened and, although nothing was going through their minds, they shouldn’t even have been there. Adomako should have known that he wasn’t up to doing this.”

**The President:** I can take two more questions.

**Dr Johns:** My name is Andrew Johns; I am a forensic psychiatrist at the Maudsley. I was listening with interest to some of your comments on expert witnesses’ expertise in criminal cases, and I would just like to pass a few observations, because clearly there have been high profile cases where medical experts in criminal cases have got things dramatically wrong. I would just like to advance the observation that I myself have found a lot of cases where the behaviour of the law and the lawyers in these cases has been extraordinary, and with no redress whatsoever; the number of times when I have received absurd instructions from either the CPS or the defence in cases of homicide, the number of times when I am encouraged by lawyers who consider highly speculative defences which I think are absurd, the number of times when instructions are late received in criminal cases, so that arguments cannot be properly dealt with. I think there are a fair number of times when the medical profession, in trying to help the court, is not as well served as it might be by some in the legal profession.

**Dr Powers:** I am very pleased you have made the remarks and I am sure that those are fully justified criticisms. There is, of course, a slight difference between the CPS and the defence, in general terms, because the Crown really has to get its act in order and be responsible. As far as the defence is concerned, it can try almost anything it likes in order to test the Crown’s case, no matter how remote the argument may be, if there is the slightest opportunity of persuading the jury to introduce that concept of doubt, so there is much, much more scope for the defence. But there is no excuse at all for either defence or for the Crown Prosecution Service not to instruct experts responsibly and timeously.

**Mr Kirton-Darling:** Edward Kirton-Darling, law graduate and researcher at the Law Commission. Given your support for corporate manslaughter, do you think that there needs to be more thought about creative remedies, or are you happy with the concept of simply damages as a remedy?

**Dr Powers:** There probably does have to be more thought to remedies, because even if we get corporate manslaughter and as a consequence some corporation is fined, you know, £100,000 for causing a death, I can’t really imagine it is going to assuage the public anger about the cause of these deaths. They will say that this will be money which will come out of the pot and maybe the shareholders will pay for it. The people who are really responsible are not going to feel the impact of it. It seems, therefore, that, if punishment is to be effective in the corporate manslaughter area, creative remedies, as you call them, by way of punishment will have to be considered in order to deal with that point.

**The President:** Well, Michael, thank you very much for your talk. We are very grateful to you and what has come out of this is the intense discussion which has followed, which gives you some indication of how well your talk has been received. Please accept this little token on our behalf.

**Dr Powers:** Well, that is extremely kind. Thank you all very much. (Applause.)