Human Error or Criminal Culpability? The Line is Blurring

Presentation given by Ragni Mathur at the Medico Legal Society Network Cocktail Event: 11 April 2018

Human error is a condition we all suffer under. Every one of us – consultants, registrars, residents, nurses, lawyers, laymen, judges and jurors. It's a condition that the profession of medicine *well* recognises contributes to adverse events.

A research paper published in the Medical Journal of Australia some years ago examining the ***cause*** of adverse events including adverse events resulting in death, found that human error was a ***prominent cause*** of adverse events.[1] ***Cognitive failures*** played a role in close to 60% of all causes of Adverse Events (57%) – and most of the adverse events were judged to be of ***high preventability.*** The adverse events were largely associated with errors of omission rather than commission.

The research paper stated:

"It is important to recognise that human error is inevitable for even the best trained and best qualified healthcare providers…the unaided human mind is incapable of performing consistently at the necessary level to provide optimal healthcare."

The author argued that what is required is a healthcare systems' whose response to error moves the system towards being as failsafe as possible ***rather*** than one that blames the clinician who may have erred.

Disturbingly however- in the criminal prosecution of doctors for gross negligent manslaughter- blame and individual accountability underpin many prosecutions.[2] The State argues that prosecuting doctors for manslaughter protects the health and safety

[1] Ross Wilson et al., 'An Analysis of the Causes of Adverse Events from the Quality in Australian Health Care Study' (1999) 170(9) *The Medical Journal of Australia* 411,

[2] Nick Barnard, 'Culpability and Mitigation' (2016) 180(2) *Criminal Law and Justice Weekly*

of the public. It is likely that the medical profession would argue strongly that prosecuting doctors and labelling their errors criminal- does the exact opposite.

Thank you to HWL Ebsworth for inviting me to speak tonight. This presentation I hope will offer some insights into the troubling intersection between medical error and criminal culpability. Last year I represented the former obstetrician and gynaecologist, Dr Graeme Reeves, who was charged with gross negligent manslaughter for his misdiagnosis of a patient's post-partum infection.

However, before I come to the prosecution of that case I thought it more pertinent to discuss the highly publicised case of the English paediatric registrar, Dr Hadiza Bawa-Garba, whose conviction for manslaughter and permanent erasure from the medical register, has sent shock waves through the medical profession. [3] Dr Bawa-Garba was a Senior Paediatric Registrar at the time of the events. Standing trial before a jury of 12, she was convicted of manslaughter. She stood trial alongside two nurses, one of whom was acquitted. Dr Bawa-Garba was sentenced to 2 years imprisonment, which was wholly suspended.

Following her conviction, the Medical Tribunal suspended her registration for 12 months.[4] The Medical Council appealed that decision, and the Appellant court "permanently erased" her name from the Register.[5] Recently, leave has been granted to appeal that decision.

There has been considerable reporting, and some misreporting about the facts in this case. For that reason I thought it best that I start with the actual facts in the case.

[3] *R v Bawa-Garba (Hadiza)* [2016] EWCA Crim 1841.
[4] *Bawa-Garba v The General Medical Council* [2015] EWHC 1277.
[5] *General Medical Council v Dr Bawa-Garba* [2018] EWHC 76, 16.

The Facts [6]

The patient was a young 6-year-old boy called Jack, who had Down Syndrome: Trisomy 21. He suffered from a hole in his heart. One consequence of his heart condition was that a valve of his heart was sometimes leaky. He was prescribed a drug, Enalapril. He had recurring episodes of croup and chest infections over the years and had had a string of previous hospital admissions.

The presenting history on the day was of fatigue, lethargy, diarrhoea and vomiting breathing difficulties; mildly elevated temperature; his peripheries were not their usual colour, and he was cold to touch. He had a high pulse rate of 120, falling into the upper limit of the normal range of between 80 and 120 beats per minute. He also had a high respiratory rate of 40, compared to the normal rate of 20. His GP raised all these issues in the referral letter to the hospital.

He presented at the Children's Assessment Unit (CAU) of Leicester Royal Infirmary in the UK. The day he presented the hospital was busy, but not unusually so. In fact, the hospital was ***calmer*** than usual for a winter's day. During the whole day, there were 39 medical patients and seven surgical patients in the CAU.

Dr Bawa Garba saw Jack shortly after arrival. He had been escalated for review by the nurse who was acquitted at trial. Dr Bawa Garba was the most senior doctor on duty that day in the CAU, although a consultant paediatrician was available and present at the hospital. At the time, Dr Bawa Garba was halfway through her paediatric training. She had returned from her 12-month maternity leave a month earlier, on the 10th January 2011.

[6] Transcript of Judges Summation to the Jury, *R v Isabel Amaro, Hadiza Bawa-Garba and Theresa Monica Taylor* (The Crown Court at Nottingham, Justice Nicol, 28 and 29 October 2015).

Her provisional diagnosis was acute gastroenteritis, with moderate dehydration. The expert evidence called by the Crown during her criminal trial was that she carried out appropriate initial investigation and management in doing the following:

1. she recognised that he needed rapid fluids and arranged for IV Boulus administration;
2. she ordered ***blood gas results*** to be obtained;
3. She ordered a ***chest X-ray;***
4. She ordered a ***full blood count;***
5. She placed a hold on ***antibiotics*** until after blood results were obtained.

Where she failed was in her subsequent management and review of these investigations. In short, the Crown alleged there were many failures by her but the most significant ones were the following:

1. <u>Misreading or misunderstanding of the Blood Gas Results</u>

Firstly, the Crown alleged that Dr Bawa-Garba misread or misunderstand the Blood Gas Results which were available about 20 minutes after they were taken and were then reviewed by her. The results showed marked abnormality in a number of areas. They strongly indicated that Jack was suffering from ***metabolic acidosis***. Jack's pH level was 7.084, outside the normal range of 7.35-7.45. His base excess reading was 14.7, while the normal range is between -2 and +2. Jack's lactate was significantly raised at 11.4, while the normal range is between 0.4-2.3. The expert evidence was that this level, at five times over the normal range, was extremely high and concerning. Blood gas results indicated that sepsis was the likely cause. The Crown's expert witness testified that these results warranted transfer to ICU and should have been recognised by a doctor of Dr Bawa Garba experience.

The defence expert conceded that the raised lactate indicated that the most likely cause was shock. He agreed that any competent doctor would appreciate that the

overwhelming likelihood was that Jack was in shock and shock should have been very much at the *forefront of the doctor's thoughts*.

2. *Repeat of Blood gas result*

Dr Bawa-Garba did complete a second blood gas test, about an hour later. Upon review she found Jack to be more alert, his peripheries were warm to touch and he was communicating with his mother. She did another clinical assessment of him but she **did not** take his blood pressure, temperature, respiratory rate, nor capillary refill time.

After the second blood gas test was done Dr Bawa-Garba had to look after a sick baby who needed a lumbar puncture. The second blood gas results showed some slight improvement, but the results were still well and truly outside the normal range. Jack showed evidence of acidosis. In her evidence, Dr Bawa Garba accepted that even the most junior doctor would recognise the abnormal readings and their implications. The defence expert conceded that a competent doctor would not have concluded from the second results that Jack was no longer in shock. He stated however that Jack did not have ***all*** the clinical signs of shock.

In short, Dr Bawa Garba misread the blood gas results. She did not recognise the strong signs that Jack was in shock and that sepsis was a very possible explanation.

3. *Failure* to Follow up Chest X-ray

The Crown alleged that Dr Bawa-Garba failure to follow up on the chest X-ray in a timely fashion was another component to her gross negligence. In the initial assessment at around 10am, Dr Bawa Garba ordered a chest x-ray which was done at 12:00pm but not viewed by her until 3pm when speaking with his mother, five hours after ordering it. She gave evidence that she had an expectation that the nurses would inform her when the results became available. She admitted "I should have checked it sooner" and agreed that she was waiting for the x-ray results to decide whether Jack had an infection and required antibiotics.

Upon review of the X-ray results, she ordered intravenous antibiotics, Cefuroxime. She did not have the full blood count results from the lab at that time and she did not do a full clinical assessment. She failed to look at the fluid balance chart and was unaware that he was having continuing diarrhoea. She was unaware that Jack's mother had changed his nappies 18-30 times in the preceding 5 hours. She was also not told that Jack had a temperature of 38.5 at 2:30pm. Further, she had not been told that the monitor reading saturation levels and pulse was not working.

Here, system failures loom large. We see a failure of both communication and recording on a systemic, rather than individual level.

4. Failure to chase up full blood test results

The Crown further alleged that Dr Bawa-Garba failed to chase up full blood count results. She had ordered a *full blood test* at the initial review, for which the usual turnaround is one hour. However, the ***ilab*** computer system was down and so these were not sent automatically. Dr Bawa Garba knew this and delegated the task of follow up by phone to a junior doctor. The blood results were not available by phone until after 4:00pm, approximately six hours after ordered. Normally, a computer-generated copy would flash green on abnormal results. However, Dr Bawa-Garba gave evidence that at her level of training, she could recognise abnormal results without the need for this coloured prompting.

The blood tests results indicated that the *C-reactive protein* was 97, while the normal range is 5. The urea reading indicated was 17.1, while the normal range is 7-8, thus falling significantly outside the normal range. This Indicated that the patient's kidneys were not excreting waste products efficiently. The creatinine reading was 252, while the normal range is below 70. The Crown's expert gave evidence that the blood test results indicated that Jack was in renal failure since the time of his arrival, when his bloods were taken. In evidence, Dr Bawa-Garba accepted she had missed the abnormal results for the urea and creatinine.

5. Failure to give a proper handover to the consultant

The Crown alleged that Dr Bawa-Garba failed to give a proper handover to the consultant at 4.30pm. There were some discrepancies in the versions between the two as to what precisely was said during the handover. The paediatric consultant rostered on gave evidence that he was not specifically asked to review Jack; he did not himself ever see Jack that day; and that Dr Bawa Garba did not raise concerns of sepsis or raise concerns at all.

Dr Bawa-Garba assumed that given the case had been discussed in some detail, the consultant would see him after the handover. However, she agreed that she had not told the consultant about the abnormal blood test results indicating renal failure.
She agreed that she had not said that Jack had been on oxygen upon admission. The Crown's expert was critical of her failure to escalate her concerns to the consultant. After 4:30pm Dr Bawa-Garba was no longer on the ward and treating Jack, however, the consultant was until 8pm.

Subsequently, Jack was transferred to a general paediatric ward. This was not Dr Bawa-Garba's decision. The transfer to the paediatric ward occurred at around 7:00pm, more than 2 hours after the blood results were known. This raises the question- did no one else look at the blood test results and recognise their significance?

Resuscitation

At around 8pm, Jack went into cardiac arrest and a crash call for all doctors was made. Shortly before this, his mother had administered the heart medication Enalapril, which Dr Bawa Garba had *not* prescribed as it can be contraindicated with dehydration. Dr Bawa Garba attended the room whilst resuscitation was underway. She mistook the boy as a '***not for resuscitation***" patient and ordered the resuscitation to stop. At this time the crash team retreated. Other doctors present noted that there was no mention of NFR in the clinical records, which was brought to Dr Bawa-Garba's attention, who realised she had made a mistake and resuscitation continued. The

error only resulted in resuscitation being stopped for a minimum of 30 seconds and one to two minutes at most.

It was **not** the prosecution's case that this mistake contributed to Jack's death. At this point he was already past the point of no return. He was bound to die whatever resuscitation efforts were or were not made. The Crown used this evidence to argue that it demonstrated Dr Bawa Garba's general lack of care and attention in treating this patient.

Dr Bawa-Garba admitted that she had confused the mothers, which led to her error. She agreed in evidence that this was not the behaviour of a competent doctor, but she said it was not symptomatic of her lack of care for Jack on that day.

The ultimate opinion of the expert was that, when all the symptoms were taken together, this was not a difficult diagnosis. His opinion was that the diagnosis was not complicated, it was *"plain like a barn door."* By this he meant that all the clinical and lab signs were obvious, even to individuals who were not specialists in the field.

Cause of Death

The cause of death was systemic sepsis complicating a streptococcal lower respiratory infection combined with Down Syndrome and the repaired hole in the heart. The respiratory infection was pneumonia, Group A Streptococcus Infection (GAS). Both the defence and Crown Expert stated that GAS was one of the most feared infections, commonly misdiagnosed and leads to very sudden deterioration and death.

Causation

Causation was a significant issue in the trial, which was contested by the defence. However, I will not focus on this element of manslaughter tonight . The Crown's expert opinion was that had appropriate treatment been provided to Jack, he would not have died at the ***same time*** or in the same circumstances that he did.

The Trial Judge sentenced Dr Bawa Garba on the basis that her failures led him to die ***significantly sooner*** than he would have otherwise.

Definition of gross negligence in criminal law (as compared to civil negligence)

The Trial Judge directed the jury that the test for gross or severe negligent manslaughter requires the Crown to prove that what Dr Bawa Garba did was:[7]

1. "***truly exceptionally bad***"
2. And ***far below*** the standards expected.

The trial judge told the jury that there was:

3. *no measuring tool as to whether any negligence was "gross*";
4. "*we leave it to juries to apply their own common and good sense, to decide whether the line has been crossed";*
5. "*using that common and good sense it is for you to decide whether the defendant whose case you are considering acted in a way that was grossly negligent*";
6. "*if you conclude she was, then it will mean that her behaviour was potentially criminal"*
7. *I say "potentially" because causation must also be proven.*

After five days of deliberation, a 10-2 majority verdict was handed down convicting Dr Bawa Garba of gross negligent manslaughter.[8]

She is not the first UK doctor to be convicted of manslaughter. In fact, statistics show that the conviction rate is on the increase in the UK, as is the number of doctors being charged in the UK.[9]

[7] Transcript of Proceedings and Judges Summation to the Jury, *R v Isabel Amaro, Hadiza Bawa-Garba and Theresa Monica Taylor* (The Crown Court at Nottingham, Justice Nicol, 28 and 29 October 2015) 6-8.
[8] Transcript of Proceedings, *R v Isabel Amaro, Hadiza Bawa-Garba and Theresa Monica Taylor* (The Crown Court at Nottingham, Justice Nicol, 28 and 29 October 2015).
[9] Quick, above p 173.

So, it begs the question: why the uproar in the profession over this case? The media reporting suggests that it is because Dr Bawa Garba was a junior doctor and there were multiple system failures in place.[10] Both of these factors are correct.

However, on one view, Dr Bawa Garba did make grave and significant errors. Her misreading of the blood gas results and full blood count is the most glaring example.

Nonetheless, the question remains- where is her moral culpability which makes her grave errors gross and criminal? When the trial judge directed the jury as to the meaning of gross criminal negligence and told them they needed to find that her conduct was *"truly exceptionally bad"*, my view is that he left out the key formulation to the test which is gross negligence ***deserving of criminal punishment.***[11] The expression "deserving of criminal punishment" imports moral culpability and in my opinion, is the tool by which one measures when the degree of negligence amounts to a crime.

Since the age of 13, all Dr Bawa Garba had ever wanted was to become a doctor. Born in Nigeria, but educated in the UK, she worked hard to complete her medical degree in the UK. At the time of her conviction, she was a single mother of two children, one of whom suffers from autism spectrum disorder. At both her trial and during the sentencing proceedings, numerous colleagues attested in graphic detail to her skills as a doctor; her absolute dedication to her patients; her strong work ethic and excellent communication skills and the high regard in which she was held by her colleagues.

The judge when sentencing said: "*there was no evidence that you neglected Jack because you were lazy or behaved for other selfish reasons. You had other patients to attend to*."

[10] Clare Dyer, 'Paediatrician Found Guilty of Manslaughter after Boy's Death from Septic Shock' (2015) 351 *British Medical Journal*.
[11] *R v Rudling* [2016] EWCA 741, [20].

The medical profession in the UK is arguably up in arms because there is a complete disjuncture between the person and doctor that Dr Bawa Garba is and a finding of criminal culpability for the unintended consequences of her error, where the context in which those errors were made was not limited to her individual failures but also system failures.

Her conviction was the subject of an appeal, which was dismissed.[12] The appeal grounds were not about the test for "gross criminal negligence" but related to the judges directions to the jury on the issue of causation.[13]

Test for Gross Negligent Manslaughter in Australia

The test in Australia, the genesis of which is found in English authorities, is as follows.

The elements of manslaughter by criminal negligence are:[14]
(i) that the accused owed a duty of care to the deceased;
(ii) that the accused breached that duty (whether by act or omission);
(iii) that the act or omission amounting to the breach of duty ***caused*** the death of the deceased;
(iv) that that act amounts to ***gross*** criminal negligence **and** merits criminal punishment.

The High Court has made a number of important statements on this test. In ***Wilson v The Queen (1992),***[15] the Court stated 'that there must be a close correlation between moral culpability and legal responsibility for manslaughter.'[16]

[12] *R v Bawa-Garba (Hadiza)* [2016] EWCA Crim 1841.
[13] Ibid.
[14] See, e.g., *Burns v the Queen* (2012) 246 CLR 334 at 345 (French CJ); *R v Adomako* (1994) 1 AC 174 at 187, *R v Taktak* (1988) 14 NSWLR 226 at 250 (Carruthers J); *R v Moore* [2015] NSWCCA 316 at [11], [64] (Bathurst J); [140] – [144] (Simpson JA).
[15] (1992) 107 ALR 257.
[16] Ibid 271.

In ***The Queen v Lavender (2005),***[17] the Court stated that *'a **fundamental principle of justice** is that **criminal liability** must not be imposed in the absence of **moral fault.**'*[18] This case involved manslaughter by unlawful and dangerous act, and was not dealing with a doctor, but an employee operating a front-end loader at a sand mine who chased kids away by driving the front loader towards them and accidentally ran over a 13-year-old boy.[19]

In ***Patel v The Queen (2012),***[20] the Court stated that '*moral culpability*' remains an ingredient when assessing the 'degree' of negligence involved.[21]

The best description of what this means, in my view is found in the words of Justice Yeldam in the decision of ***Taktak:***[22]

> *Mere negligence will not do, there must be **wicked** negligence, that is, negligence **so great**, that you must be of the opinion the prisoner had a wicked mind, in the sense that she was **reckless and careless whether the creature died or not.***[23]

That description is closely aligned to what was said in the leading case for manslaughter- an English decision of 1925, ***Bateman***:[24]

> *The crown must prove that the negligence of incompetence of the accused went beyond a mere matter of compensation and showed **such a disregard for the life and safety of others as to amount to a crime against the State – deserving of criminal punishment."***[25]

[17] [2005] HCA 37.
[18] Ibid [130].
[19] Ibid.
[20] [2012] HCA 29.
[21] Ibid [97]- [99].
[22] *R v Taktak* (1998) 14 NSWLE 226.
[23] Ibid 250.
[24] (1925) 19 Cr App R 8.
[25] Ibid.

This was adopted by the House of Lords in **Adomako**[26] in 1994.

Dr Bateman was a doctor, who in the course of delivering a baby in breech position at a home birth in 1924, conducted a manual version and mistakenly removed portion of the woman's uterus, causing other internal damage resulting in death a week later.[27] Her admission to hospital was delayed by 5 days.[28] Dr Bateman's conviction was overturned on appeal.[29]

In 1867, in the decision of ***Assizes***, the court held that gross and culpable negligence required proof of an ***evil mind.***

In my opinion, to speak of a *wicked* mind or an *evil* mind is to speak of moral blameworthiness which is conduct that has a place in the criminal law.

To leave such descriptions out of directions to the jury and leave it as simply conduct that is "*truly exceptionally bad*" can result in my opinion in unsafe or unsatisfactory convictions.

Academics

Academics have argued that the test for gross criminal manslaughter is unclear, unprincipled, often unfair and ought to be abolished. It is incapable of clear and objective measurement.

In the UK case ***Misra and Srivastava***,[30] in which two orthopaedic registrars missed signs of a post-operative infection, it was argued on appeal that the **vagueness** of 'gross negligence…offends the principle of legality and transparency."[31] They criticised

[26] [1995] 1 AC 171.
[27] Oliver Quick, 'Medical manslaughter – time for a rethink?' (2017) 85(4) *Medico-Legal Journal* 173, 173.
[28] Ibid.
[29] Oliver Quick, 'Medicine, Mistakes and Manslaughter: A Criminal Combination?' (2010) 69(1) *The Cambridge Law Journal* 186, 188.
[30] [2005] 1 Cr App R 328.
[31] Quick, above 189.

earlier decisions and argued the current test is circular – namely, "*it is a crime if the jury think it* ***ought*** *be a crime."*[32]

Other academics argue that ***subjective recklessness*** ought be an element of the crime. Namely, that recklessness must be proved beyond reasonable doubt. I agree; at a minimum, recklessness should be imported into the test. Currently, the state of mind of the doctor – their intent – is not relevant.

The reality is that often cases that lead to convictions are classic subjective recklessness. Take the following UK examples.

In ***Misra***,[33] orthopaedic registrars failed to treat a post-operative bacterial infection and failed to take blood cultures and review blood results, despite the repeated urging of nurses and other clinicians raising their concern about the patient's condition.[34]

In the case of **Dr Walker** removed a large liver tumour ***despite*** warnings that it was too dangerous to do so.

Dr Sinha gave a fatal morphine dose to relieve pain of severe arthritis in a patient with kidney failure where he **refused** to read the patient's medical chart which was offered by patient's husband. He closed his mind to the risk.

Dr Ramnath gave a fatal dose of adrenalin against the advice of 3 colleagues, which was regarded as a professional violation.

Australia has seen very few prosecutions of doctors for medical negligent manslaughter.

[32] Quick, above 189.
[33] [2005] 1 Cr App R 328.
[34] Quick, above 174.

Of those prosecuted which proceeded to trial, there has only been one conviction after trial that I'm aware of. This was for **Dr William Valentine**, who was tried for manslaughter in Tasmania in 1843, when it was still Van Diemans Land.[35] He intended to send a sick patient black draught – a laxative – herbal type remedy for all sorts of ailments, but erroneously sent a bottle of Laudunum11, an opiate with a high morphine content. The patient consumed it and died.

The jury returned a verdict of guilty but asked the Judge to show ***great mercy*** to the doctor when he imposed his sentence, which the good Judge did. Doctor Valentine was fined ***25 pounds*** and sent home.[36]

Other prosecutions include Dr Bailey, a Chelmsford doctor, was charged in 1983 but died before trial. Dr Gill, another Chelmsford doctor, was charged in 1992 but the prosecution was stayed.[37]

Dr Reimers, an anaesthetist, who failed to notice that a 72-year-old patient had stopped breathing on the operating table and the patient subsequently died of brain damage. The NSW District Court found him not guilty. Subsequently, after criminal trial, information emerged concerning his drug taking during surgeries and he was struck off for 10 years.

Dr Pegios, a NSW dentist, was tried by judge alone and was found not guilty. In performing a dental implant procedure, he used intravenous sedation to reduce the patient's anxiety, following which the patient suffered critical blood loss saturation and died of hypoxic damage.

[35] *R v Valentine* [1842] TasSupC 4.
[36] Ibid.
[37] Ian Dobinson, 'Doctors who Harm and Kill their Patients: the Australian Experience' in Danielle Griffiths and Andrew Sanders, *Bioethics, Medicine and the Criminal Law* (Cambridge University Press, 2013) 248, 256.

Dr Patel, on retrial after the High Court overturned his earlier convictions, was acquitted by a jury on all counts.[38]

Lastly, **Dr Reeves**, the obstetrician/ gynaecologist who I appeared for last year in his trial for manslaughter was acquitted.[39] The prosecution of Dr Reeves for manslaughter was an injustice on so many levels. While it is difficult for me to be objective, objectively speaking, it was a witch-hunt. The case dates back to events that occurred 20 years before his prosecution, when Dr Reeve's patient died 5 days after delivering her third son at Hills Private Hospital in Baulkham Hills. The patient died from puerperal sepsis, namely a post-partum bacterial infection. The Crown case in essence was that Reeves misdiagnosed the deceased post-partum symptoms as a viral infection, rather than a bacterial infection, resulting in no course of antibiotics being administered. She died from septicaemia, Strep A infection (GAS).

The disturbing fact in Reeves's case was that the facts and circumstances were known, thoroughly investigated and prosecuted by HCCC before the Professional Standards Committee in 1997. Dr Reeves was not de-registered at that point in time but had conditions placed on his registration. The State prosecuted him for manslaughter 20 years after the event, at a time when he was no longer practising medicine and was no longer registered, having been struck off 13 years earlier in 2004 after a series of other clinical failures. There was no public interest and no public health and safety to protect given that he was no longer treating patients.

We argued four main points as to why the misdiagnosis by Reeves did not amount to gross negligence deserving of criminal punishment. Firstly, the condition that Reeves failed to diagnose was exceedingly rare**.** Secondly, sepsis is and has always been elusive. We relied on research studies showing that GAS infections during pregnancy or in the postpartum period can be difficult to diagnose because of the rarity of invasive GAS disease, and because signs and symptoms mimic many other illnesses-

[38] *Patel v R* (2012) 247 CLR 531.
[39] *R v Reeves* (Unreported, The District Court of New South Wales, Zahra J, 16 June 2017).

as one expert stated in evidence "*Diagnosing sepsis is actually* ***one of the most difficult*** *things to do, sometimes, to get it right*."

Thirdly, the presentation of the deceased was atypical. She had none of the classic risk factors associated with puerperal sepsis; and her symptoms of fever and tachycardia which are known to be markers of septicaemia are non-specific. Other classic symptoms of puerperal sepsis which are often present were not in this case; namely, her uterus was well contracted, the fundus was firm, lochia was moderate, she was voiding well and she was ambulant.

Fourthly**,** Reeves's failure did not occur in a vacuum. His case was a classic case not of an individual failure amounting to a 'felony' by a specialist, but of a system failure resulting in the tragic death of a patient. Every single clinician who treated the deceased, including 18 nurses, 14 of whom were trained midwifes and three doctors- who were specifically asked to review the patient's condition; missed the differential diagnosis of bacterial sepsis. Not one of them raised with Reeves the issue of puerperal sepsis- in any way, at any time. Even when she was transferred to Westmead Hospital with a differential diagnosis of sepsis, she lay somewhere in no man's land for about 2 hours without being seen.

Lastly**,** we relied heavily on the opinions expressed by peer review experts called by the HCCC in the PSC prosecution in 1997, who were on balance only mildly to moderately critical of his failure in diagnosis.

It was a prosecution that should never have happened

So, why did it?

An article published in the UK *Medico-Legal Journal* last year listed these key factors influencing "*the road to the dock*":[40]

[40] Quick, above n , 176.

- The character of the victim (especially age and vulnerability);
- Families being active and searching for justice through the criminal law system;
- Publicity;
- The role of the coroners: both Bawa Garba and Reeves cases were referred from Coroner;
- Interviews of suspects;
- Selection and instruction of experts: in Reeves's case, I found one of the most disturbing features of the case was the lack of impartiality in some of the Crowns expert witnesses; and
- The role of the Officer in Charge and Senior Prosecutors.

Operation of the Criminal Law

Prosecuting doctors in the criminal courts for their clinical errors is not new. The first reported case dates back to 1329, a decision handed down in medieval French.[41] As a result- I unfortunately have no idea what it says.

The fact that criminal prosecution of doctors is not new should not silence the profession, both legal and medical, from having a robust debate about whether the criminal law is the appropriate vehicle for dealing with clinical errors. It is inarguable that disciplinary prosecutions, by the HCCC before the Medical Tribunal, have a real and important role to play both in protecting the community and in protecting the good repute of the medical profession.

But is the criminal law the correct vehicle?

Academics have argued that the State chooses the criminal law when it wishes to convey moral condemnation of behaviour. And as we know, that is not a *static* state of affairs.

[41] Oliver Quick, 'Medical manslaughter – time for a rethink?' (2017) 85(4) *Medico-Legal Journal* 173, 173.

You can no longer have non-consensual sex with your wife without being charged and prosecuted; you can no longer physically assault the school child with a ruler to the bare bottom; domestic violence is no longer the domain of the family courts, but the criminal court; traffic offences are not limited to the insurance industry and civil remedies but rather they can result in terms of full time imprisonment, for example, for dangerous driving causing death.

Society now views all the above conduct as criminal- when previously it did not.

It has been argued that the criminal law has many purposes that it achieves with varying degrees of success. But the one thing it does well is denunciation. Denunciation through individual responsibility and punishment. Denunciation by the state conveys the message that certain behaviours are morally unacceptable-reprehensible.

Convictions lead to sentencing- and sentencing is governed by a number of principles- two of which in my opinion do not fit well with clinical errors.

1. **Deterrence**

Deterrence is both specific and general. Relevant questions in this context are: how to deter an individual doctor or the medical profession at large from the "***inevitability of their human errors***"; how to deter an individual or a profession from the *unintended consequences* of their treatment of sick patients; and how to deter an individual or the profession from avoiding system failures- computer glitches/delayed results/overcrowded hospitals? Surely punishing doctors will not deter individuals or the profession from future latent human errors.

Deterrence seems an odd concept to justify the criminal prosecution of doctors.

2. **Punishment**

Any doctor in a hospital setting is working in a high-risk situation. They are dealing with patients sufficiently unwell to warrant admission. Punishing them for making mistakes under pressure seems at total odds with trying to achieve patient safety and optimal care. Patient health and safety is surely best achieved by asking doctors to ***admit*** their errors, ***reflect*** on their errors and partake in continued training to reduce the risk of future errors. If their errors are truly exceptionally bad, in the absence of moral culpability, disciplinary prosecution adequately and effectively addresses patient health and safety.

Conclusion

I would like to end where the criminal law really commenced in relation to prosecuting doctors – the first cluster of cases in the 1800's.

In 1859, in a decision of ***Crick***,[42] the accused was a "herb doctor" and gave a child some lobelia, an acro narcotic poison prescribed by doctors. Lord Pollock stated:

> *"If the prisoner had been a medical man, I should have recommended to you to take **the most favourable view** of his conduct, for it would be **most fatal to the efficiency of the medical profession**, if no one could administer medicine without a halter round his neck"*

A verdict of not guilty was returned.

In the 1807 case of ***Williamson***,[43] a man midwife tore away part of the prolapsed uterus of his patient. The court directed the jury:

> *"it appears to me that if you find the prisoner guilty of manslaughter, it will tend to encompass a most important and anxious profession- with such dangers- as would deter reflecting men from entering into it."*

[42] [1859] 1 F. & F. 520.
[43] [1807] 3 CAR & P 635.

And these days, his Lordship would have certainly added - *deter reflecting women from entering the profession.*"

Thank you.