8 November 2012

Girton College, Cambridge
“When medicine goes wrong – the hospital and patient perspective – a case study”

Sandra Patton
Head of Medical Injury – Ashton KCJ

Jan Perkins
Solicitor, Litigation and Complaints Manager – Norfolk and Norwich University Hospital
What are we trying to achieve?

• Find out what happened
• Stop it happening again
• Restore patient to health, insofar as possible.
Mrs Ethel Smith

The Investigation

Hospital
Investigation of incidents / Serious incidents (SI)
Reporting to external agencies

Patient
Negligence
Product liability

The Outcome

Hospital
Learn Lessons to improve practice
Prevent harm to others

Patient
Damages
Other benefits?
The Investigation
Scenario
Mrs Ethel Smith

- Mrs Ethel Smith, 78 year old, widowed and lives alone

- Previous cataract extraction and lens implant (left) → tear to posterior capsule and dropped nucleus

- Vitrectomy – retinal detachment occurred which required gas

- The air pump switched itself off → loss of intraocular pressure → Expulsive haemorrhage → permanent loss of vision in left eye.
Incident Reporting

- Policy for reporting, management & investigation of incidents, near misses & serious incidents (SI)

- “…the response to an incident should not be one of blame and retribution but of organisational learning with the aim of encouraging participation …and supporting staff rather than exposing them to recrimination.”
Serious Incident

A SI is an incident that has occurred in relation to NHS-funded services and care resulting in:

- Unexpected or avoidable death patients, staff, visitors or members of the public
- Serious harm to patients etc
- A scenario that prevents or threatens to prevent a provider organisation’s ability to continue to deliver healthcare services ie IT failure
- Allegations of abuse
- Death in custody e.g. prison, probation hostels
- Potential or actual adverse media coverage or public concern about the organisation or the wider NHS
- One of the DOH ‘Never Events’.

The “never events” list
Lines of Enquiry

The Clinical Team

The Patient

The Manufacturer

The Medical Engineer

Facilities-Electrical Supply

Norfolk and Norwich University Hospitals NHS Foundation Trust

Ashton KCJ

November 2012 © Ashton KCJ
### SI Reported to ..........

<table>
<thead>
<tr>
<th>Internal</th>
<th>External</th>
<th>NHS Bodies</th>
</tr>
</thead>
<tbody>
<tr>
<td>The patient</td>
<td>MHRA</td>
<td>SHA</td>
</tr>
<tr>
<td>Clinical Team</td>
<td>NPSA</td>
<td>PCT</td>
</tr>
<tr>
<td>Risk Manager</td>
<td>Manufacturer</td>
<td>(NHSLA)</td>
</tr>
<tr>
<td>Clinical Governance</td>
<td>Engineering company (service)</td>
<td>(CQC)</td>
</tr>
<tr>
<td>EME Dept</td>
<td></td>
<td>(Monitor)</td>
</tr>
<tr>
<td>NHS Estates</td>
<td>(Police)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(HSE)</td>
<td></td>
</tr>
</tbody>
</table>
• It is important to patients/relatives that they receive a meaningful apology. Apologies do not constitute an admission of liability.

• NHSLA encourages both clinicians and NHS bodies to supply appropriate information whether informally, formally or through mediation.

• The provision of such information constitutes good clinical and managerial practice.
Why do patients sue?

• Explanation
• Prevention
• Apology
• Money

Norfolk and Norwich University Hospitals
NHS Foundation Trust

AshtonKCj

November 2012 © Ashton KCJ
Is there a claim?
The Legal bit

Product Liability

Consumer Protection Act 1987
- safety of product not as entitled to expect
- causes injury

Negligence

- breach of duty
  standard of reasonably competent practitioner
  ‘reputable minority’ defence

- causation
  ‘but for’ test.
Investigating the Claim

- Medical records
- Client’s account
- Expert report
- Pre-action protocol
- Admission – value claim
- Denial – issue claim
The Remedy

Damages
Explanation
Reassurance
Wider benefits?
Review practice/policy
Learn lessons for future practice
Improve patient care

Norfolk and Norwich University Hospitals
NHS Foundation Trust

AshtonKCj

November 2012 © Ashton KCJ
sandra.patton@ashtonkcj.co.uk
01842 768736
jan.perkins@nnuh.nhs.uk
01603 289687
Doctors in the dock
Criminal liability for medical care

8 November 2012
Duncan Astill
Your speaker

duncan.astill@mills-reeve.com
01223 222477
01223 222220
What we will cover

- When is the criminal law invoked?
- Consequences of non-compliance
- Interesting cases
- Questions
When is the criminal law invoked?

Manslaughter by Gross Negligence
Gross Negligence Manslaughter

- Did the defendant owe a duty of care to the deceased?
- If so was he/she in breach of that duty?
- Was that breach of duty a substantial cause of death?
- Should the breach of duty be characterised as gross negligence and therefore as a crime?
Actions will be judged in light of particular skills and knowledge s/he has - this is an **objective test**.

Would the risk have been obvious to a reasonable person in the doctor’s shoes?

The jury decides whether a doctor’s actions were poor enough to amount to a criminal act or omission. The act would have to be “reprehensible” (R v Misra and Srivastava [2005])
Manslaughter prosecutions

- 85 doctors charged with manslaughter since 1795.
- Number dramatically increased since 1990.
- 60 acquitted,
- 22 convicted,
- 3 pleaded guilty.
- Most doctors charged as a consequence of mistakes (37) or slips (17), and a minority because of alleged violations (16).
Corporate Manslaughter and Corporate Homicide Act 2007

2007 CHAPTER 19

An Act to create a new offence that, in England and Wales or Northern Ireland, is to be called corporate manslaughter and, in Scotland, is to be called corporate homicide; and to make provision in connection with that offence.
[26th July 2007]

BE IT ENACTED by the Queen’s most Excellent Majesty, by and with the advice and consent of the Lords Spiritual and Temporal, and Commons, in this present Parliament assembled, and by the authority of the same, as follows:—
Corporate Manslaughter

Corporate Manslaughter and Corporate Homicide Act 2007 (the Act) - Landmark.

Organisations will be guilty of offence if way activities are managed or organised causes death and amounts to a gross breach of a relevant duty of care.
Corporate Manslaughter (cont)

- What is meant by “gross breach”?
- Organisation’s conduct must have fallen far below what could have been reasonably expected.
- Juries will consider health and safety breaches by the organisation and how serious/dangerous these were.
Corporate Manslaughter (cont)

- Duty of care?
- Duties are set out in section 2(1) of the Act. The relevant duty for NHS organisations would be “supplying goods and services…”
- Exists in respect of systems of work, equipment used by employees, condition of worksites/premises.
- No new duties created by the Act - already exists in statute and civil law of negligence - new offence is based on these.
Corporate Manslaughter (cont)

- Cause of death must be directly attributable to “senior management”.

- Section 1 (4) of the Act defines “senior management” as “…the persons who play significant roles in—
  (i) the making of decisions about how the whole or a substantial part of its activities are to be managed or organised, or
  (ii) the actual managing or organising of the whole or a substantial part of those activities”
Corporate Manslaughter (cont)

- Senior management - centralised, headquarters functions as well as those in operational management roles.
- Those who make significant decisions about the organisation/substantial parts of it.
Health and Safety at Work Act 1974

Organisations

- S.2 Duty of every employer to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all employees.

- This includes:
  - provision and maintenance of safe systems of work;
  - provision of information, instruction, training and supervision to ensure health and safety at work; and
  - provision and maintenance of a safe working environment.
S2(3) Duty to prepare (and revise when needed) statement of health and safety policy and bring it to the attention of employees. Statement should also explain arrangements in place for the implementation of the policy.
Health and Safety at Work Act 1974 (cont)

- S.3 Duty to ensure, so far as is reasonably practicable, that persons not employed by organisation are not exposed to risks to their health or safety.

- Section 2 and 3 duties are qualified by the principle “so far as is reasonably practicable. What does this mean?

- It involves weighing a risk against the trouble and money needed to control/reduce it. So risk reducing measures should be introduced unless they involve grossly disproportionate sacrifices.
Health and Safety at Work Act 1974 (cont)

What would be grossly disproportionate?

- To spend £1m to prevent five staff suffering bruised knees is obviously grossly disproportionate; but
- To spend £1m to prevent a major explosion capable of killing 150 people is obviously proportionate.

(HSE)
Health and Safety at Work Act 1974 (cont)

Individuals

- S.7 Duty of every employee while at work to:
  - take reasonable care for the health and safety of himself and, of other persons who may be affected by his acts or omissions at work; and
  - Co-operate with employer to enable employer to comply with health and safety requirements imposed on them.

- S.8 Duty to not intentionally or recklessly interfere with or misuse anything provided in the interests of health, safety or welfare (safety equipment).
Consequences of non-compliance
Consequences of non-compliance

- It is important to note that the more recent offence of Corporate Manslaughter is intended to work hand-in-hand with other offences like gross negligence manslaughter and breaches under the Health and Safety at Work Act.

- It is therefore not an either/or situation- prosecution under these three offences may all be pursued.
Gross Negligence Manslaughter

- Although manslaughter carries a maximum penalty of life imprisonment, sentences are usually significantly more lenient.
- For example, in May 2012 Dr Sudhanshu Garg was sentenced to 2 years imprisonment for the gross negligence manslaughter of Lisa Quinn who died in Bradford Royal Infirmary.
Corporate Manslaughter

Three main consequences of prosecution:
1. unlimited fine;
2. a publicity order; and
3. a remedial order.
Corporate Manslaughter (cont)

Unlimited fine

- Level is relevant to means—will seldom be less than £500,000 but Cotswold Geotechnical Holdings Ltd £385,000 payable over 10 years (company had virtually no assets).

- Most recent—Lion Steel Ltd fined £480,000 (four annual instalments by September 2015) plus £84,000 towards prosecution costs.
Corporate Manslaughter (cont)

Publicity order

- Organisation required to publish fact that it has been convicted of offence, details of offence (as directed by court).
- Court must consult relevant enforcement authority about the terms of the publicity order.
- Evidence may need to be submitted to an enforcing authority (e.g. HSE) to show compliance.
Corporate Manslaughter (cont)

Remedial order

- Requires the organisations to remedy cause/s of fatality and any health and safety deficiencies in the organisation.
- HSE may be consulted to identify relevant standards to assist the CPS in drafting the order.
- Failure to take action may result in further prosecution by the CPS.
Corporate Manslaughter (cont)

- Organisation could be charged with both an offence under the 2007 Act and under health and safety legislation in the same proceedings.
- If organisation is convicted of corporate manslaughter the jury may still be asked to return a verdict on the health and safety charges in the interests of justice.
Corporate Manslaughter (cont)

Who will be in the dock?

- While the prosecution would be brought against the organisation and not individuals, directors, managers and other employees may be called as witnesses.

- Factors for court consideration might include:
  - Systems used by employees;
  - Levels of training and adequacy of equipment;
  - Issues of immediate supervision and middle management; and
  - Organisation’s strategic approach to health and safety.
Health and Safety at Work Act 1974

- Fine – should seldom be less than £100,000.
- Imprisonment
- Disqualification
Additional consequences

- **Disciplinary action by regulatory body (e.g. GMC)** - This could lead to doctor/s being struck of the register.

- **Negative publicity** - Harmful to individual careers and reputation and consequently public trust in NHS organisations.

- **HSE public inquiry** - In serious cases involving multiple deaths the HSE, with the consent of the Secretary of State, may direct that a public inquiry be held. A formal investigation would be conducted and a report produced by the HSE or another authorised person.
Additional consequences (Cont)

- **Compensation** - Family of the deceased/injured may seek compensation although this is likely to be dealt with in a civil court.

- **Costs** - The defendant will ordinarily be ordered to pay the properly incurred costs of the prosecution.

- **Inquest** - Must be heard when:
  - Death is violent and unnatural death;
  - Cause of death is unknown;
  - Death occurs in prison or place/circumstances requiring inquest by law.
Example cases

Doctors in the dock - Case 1


- During an operation tube became disconnected from ventilator and patient died through lack of oxygen.

- Duty of anaesthetist to sit by the side of the patient to ensure safety.

- He failed to read warning signs produced by machines.
Example cases (cont)

- Four stage test for gross negligence manslaughter:
  - First establish a duty of care was owed by the defendant towards the victim who has died.
  - If a breach of duty is established the next question is whether that breach of duty caused the death of the victim.
  - If so, the jury must go on to consider whether that breach of duty should be characterised as gross negligence and therefore as a crime.
Example cases (cont)

- Jury found Adomako guilty of manslaughter.
- Sentenced to six months’ imprisonment, suspended for 12 months.
- Decision upheld on appeal.
Example cases (cont)

Doctors in the dock - Case 2

- **R v Misra and Srivastava (2004)**
- Victim - Sean Phillips
- Minor surgery to repair patella tendon.
- Developed infection leading to death.
- 2 Junior doctors failed to treat him properly.
- Found guilty of manslaughter by gross negligence and sentenced to 18 months imprisonment, suspended for two years.
Example cases (cont)

Doctors in the dock - Case 3

- Dr Robert Falconer (2004) - Consultant Anaesthetist
- Accidentally killed six-week old baby by injecting air into bloodstream.
- Charged with manslaughter through gross negligence.
- Acquitted.
Interesting cases (cont)

Organisations under fire! – Case 1

- R v Southampton University Hospital NHS Trust (2006)
- Prosecution of the trust following death of Sean Phillips (R v Misra and Srivastava (2004)).
- Serious failures in the appellant’s management and systems, in particular the supervision of the SHOs in the trauma and orthopaedic department of the hospital.
- Failed to properly supervise Drs Misra and Srivastava and other SHOs.
Example cases (cont)

- Fine of £100,000 quashed on appeal and substituted for £40,000.
- Lower court had not given sufficient weight to mitigating factors.
Prevention is better than cure

- Be proactive; Identify and assess hazards.
- Don’t wait for the plane to crash and pick over the pieces.
Any questions?
thank you