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Gross Negligence Manslaughter: Medical, drug and food related deaths

By Dr Oliver Quick & Felicity Gerry QC

"Of all crimes manslaughter appears to afford most difficulties of definition, for it concerns homicide in so many and so varying conditions."

Lord Atkin's words from *Andrews v DPP* [1937] AC 576 continue to ring true today and are illustrated by several recent appeal cases. Problems continue to surround defining "gross negligence", interpreting legal causation in different contexts, and maintaining a clear boundary between manslaughter by gross negligence and unlawful and dangerous acts.

This short article draws on a recent Libertas webinar featuring Dr Oliver Quick and our Felicity Gerry QC which reviewed recent cases involving medical, drug and food related deaths and identified areas of ongoing uncertainty and controversy.

The complexities in such cases were recently highlighted in *R v Rebelo (No1)* [2019] EWCA Crim 633 in which Felicity Gerry QC appeared and *R v Rebelo (No2)* [2021] EWCA Crim 306. Those appeals from the trial and retrial related to the supply of diet pills in capsule form made from an industrial chemical. The indictment alleged a food regulatory offence and both unlawful act manslaughter and gross negligence manslaughter. The evidence was that the Appellant supplied the capsules by post following an online order from the deceased. The chemical was not combustible so was not dangerous per se, but experts gave evidence that it was unpredictable and thus dangerous, if ingested. Experts also gave evidence that the deceased was vulnerable as someone suffering from an eating disorder from her medical notes, and that she lacked capacity to make sensible decisions about her eating. Computer records showed that she had she had done considerable research and knew exactly what she

was taking and that she was highly intelligent so appeared to understand the risks. Text messages tragically recorded her dying communications suggesting she had taken an erroneous dose.

Put shortly, the Court of Appeal in *Rebelo (No 1)* accepted that posting such an item (unlike throwing concrete from a bridge – see *DPP v Newbury* [1977] AC 500) is not an unlawful and dangerous act that caused her death. The failure to comply with a food regulation was not sufficient. The Court of Appeal, led by Leveson P, rejected the prosecution suggestion that causation was proved if the deceased lacked capacity and accepted defence submissions to apply the classic definition of autonomy – whether she was 'free, informed and deliberate' such that the 'chain of causation' from the supplier was broken. It was an attempt to explain the relationship between constructive and negligent manslaughter which was explained and reaffirmed in *Rebelo (No2)* with Dame Victoria Sharp P now in the Chair, following Sir Brian's retirement. The conviction for unlawful and dangerous act manslaughter was quashed. Mr Rebelo was convicted at retrial of gross negligent manslaughter and his subsequent appeal was dismissed.

The consequence in such cases is that 'free, informed and deliberate' is dealt with as largely a question of fact. Nonetheless, this does not end the complexities in gross negligent manslaughter trials. Given the rare circumstances of food related deaths, it is useful to consider this area of law in the broader context of medical, drug and food related deaths:

Defining (medical) manslaughter by gross negligence

Cases involving doctors have undoubtedly shaped the common law of involuntary manslaughter. Such cases are not new. The first known prosecution of a health professional occurred in 1329 where a man was "commended" to God at a court in Newcastle.[1] Negligent homicide can be traced to the 16th Century and the reference to "gross" emerged in the 19th Century. Interestingly, at this time judges were less concerned about separating gross negligence from

[1] We are grateful to Ian Barker, senior solicitor at the Medical Defence Union, for providing this source.

recklessness, which became a focus of 20th century legal philosophy and the common law.

Strictly speaking, the House of Lords decision in *R v Adomako* [1995] 1 AC 171 remains the leading case on manslaughter by gross negligence. John Adomako, a locum anaesthetist, lost his appeal after fatally failing to spot a disconnected oxygen tube during a routine eye operation. Lord Mackay set out the following four stage test for determining liability:

a) the existence of a duty of care to the deceased;

b) a breach of that duty of care which;

c) causes (or significantly contributes) to the death of the victim; and

d) "whether the extent to which the defendant's misconduct departed from the proper standard of care … involving as it must have done, a risk of death to the patient, was such that it should be judged criminal …" (the 'gross negligence' element)

This test, especially paragraph (d), has long been criticised for its vagueness and circularity. These objections formed the basis of the unsuccessful appeal arguments in *R v Misra, Srivastava* [2004] EWCA Crim 2375, after two junior doctors failed to diagnose and treat toxic shock syndrome in a patient recovering from a routine knee operation. The Court of Appeal's reasoning that there was "uncertainty about the outcome of the decision-making process, but not unacceptable uncertainty about the offence itself" has always been unconvincing – the shape of the substantive law and the criminal process are clearly connected.

This denial of uncertainty has been disproved by a series of appeal cases over the last decade. The successful appeal in *R v Sellu* [2016] EWCA Crim 1716, after a colorectal surgeon served 15 months in prison, was the catalyst for a significant narrowing of the test for liability through a series of appeals all presided over by Sir Brian Leveson. The most significant is *R v Rose* [2017] EWCA 1168, where an optometrist failed to conduct a proper eye exam on a young boy who died 4 months later of acute hydrocephalus secondary to undiagnosed papilloedema.

In allowing her appeal, the four stage *Adomako* test has expanded into five stages:

(a) duty of care

(b) negligent breach

(c) reasonably foreseeable that the breach gave rise to a serious and obvious risk of death

(d) breach caused the death

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

To be clear, the point in paragraph (c) on the risk of death is not new, but the emphasis on serious and obvious risk of death being reasonably foreseeable, *based on what the defendant knew at that time*, is significant. Controversially, the fact that Honey Rose failed to comply with her statutory responsibility to conduct a proper eye exam, and thus saw no evidence of papilloedema, was of critical relevance on this revised formulation. This narrower test (reasonable foreseeability of a serious and obvious risk to the reasonable person in the defendant's position) mitigates the potential breadth (and harshness) of gross negligence manslaughter. It has also been separated from the gross negligence element (para e) when the *Adomako* test approached both as part of same question. The running order of the different elements has also changed – causation originally preceded the risk of death and negligence elements.

Common law evolution

Has *R v Rose* changed or just re-formatted the common law? This remains a moot point, but it does appear to narrow the offence and to makes successful prosecution a tougher task. What is meant by serious and obvious? And why are both needed? Jurors might (not unreasonably) think that obvious risks of death are serious and that serious risks should be obvious? There has been little clarification, beyond noting that 'serious' qualifies the nature of the risk of death

as something much more than minimal or remote. An obvious risk is one that is present, clear, and unambiguous. It is immediately apparent, striking and glaring rather than something that might become apparent on further investigation.

How does this test apply in other contexts, for example food safety? *R v Kuddus* [2019] EWCA Crim 837 involved a restaurant owner and chef who prepared a meal containing peanut proteins to a girl who identified this allergy on the takeaway order. In short, there was no evidence that Kuddus saw this information which was the basis for quashing his conviction. In both *Rose* and *Kuddus*, the Court of Appeal concluded that neither defendant knew about circumstances which made the risk of death serious and obvious – even though they should have known. This poses a key question - is gross negligence an objective or subjective form of fault? In theory it is supposed to be objective – after all, that is the whole point of negligence liability. In reality of course, the common law has created something of a hybrid model. A close reading of *Adomako* and *Misra* reveals that recklessness is still in play in terms of assessing gross negligence. *Rose* and *Kuddus* are more recent examples where absence of recklessness remains critical. Ultimately, the reasonably foreseeable serious and obvious risk of death (for this defendant) dilutes the objective nature of gross negligence.

Causation

Legal causation has always been complex, despite the apparent simplicity of being sure that the defendant's conduct made a significant (i.e., more than minimal) contribution to the outcome. Recent cases have illustrated various difficulties in determining this critical question. *R v Sellu* involved the temporal relationship between elements of the offence and determining the point at which gross negligence is relevant to causation. *R v Bawa-Garba* [2016] EWCA Crim 1841 involved a possible (though dismissed) intervening act, namely the administration of prescribed medication by the victim's mother, which was against Dr Bawa-Garba's judgement, albeit she had failed to document this in the clinical notes which would have alerted nursing staff and the mother.

A recent drug induced homicide case appears to raise the bar for establishing causation. In *R v Broughton* [2020] EWCA Crim 1093 a 24-year-old woman died at a Music Festival having taken a 'bumped up' dose of 2-CP, a Class A drug,

supplied by her boyfriend, the appellant. It was alleged that he was grossly negligent in failing to obtain the on-site medical assistance and that this failure caused her death. His conviction was quashed on the basis that the case should have been withdrawn from jury as the evidence could not establish causation to the criminal standard. There was a single expert on causation who estimated that the chances of survival with medical care at 90% but that survival could not be guaranteed. The following two passages from the judgment summarise the Court's approach:

"The prosecution must prove to the criminal standard that the gross negligence was at least a substantial contributory cause of death. That means that the prosecution must prove that the deceased would have lived in the sense that life would have been significantly prolonged." (Lord Burnett, LCJ, para 23)

"In the context of causation in this very sad case the task of the jury was to ask whether the evidence established to the criminal standard that, with medical intervention as soon as possible after Louella's condition presented a serious and obvious risk of death, she would have lived." (para 100)

On the face of it, in requiring the crown to prove that deceased "would have lived" appears to place the bar impossibly high. Arguably, it implies a certainty which is neither possible or necessary. Experts are always likely to eschew absolute certainty and talk in terms of probabilities, and juries are entitled to make their own mind up based on all the evidence. Beyond reasonable doubt has never meant being 100% certain.

It is striking that so much reliance is placed on *R v Morby* (1882) 8 QBD where a father failed to seek medical assistance for his 8-year-old son with smallpox, and a lead judgment of just 17 lines which has largely been uncited in 134 years (it was cited in *Sellu* and *Bawa-Garba*). Applying this *Broughton* approach to the medical cases, especially *Misra* and *Bawa-Garba*, then lingering doubts about causation in those scenarios become even more apparent. In *Misra*, the expert described a "very high chance of survival" and that "on the balance of probability" the deceased would have survived if not for the defendant's gross negligence. In *Sellu* there was a "significant chance of saving life" (his appeal was successful, but not on causation grounds.) In *Bawa-Garba*, the risk of death on admission for the victim was quantified as being between 4-20 % and the jury was directed that

"significant is left to your good sense, although it must be more than trivial or minimal."

Perhaps, the unstated view in *Broughton* was that the dominant cause of death was ingesting the drugs, and not the failure to obtain assistance? And that the drugs supplied by the appellant were less likely to cause death than heroin, as in the case of *R v Evans* [2009] EWCA Crim 650, an otherwise similar scenario, where the conviction was upheld. It also likely reflects continuing unease with manslaughter by omitting to seek assistance on the basis that omissions do not start causal processes but rather allow other causal processes to unfold. However, in *Broughton*, the appellant supplied the drugs, so this point falls away. Ultimately, the Broughton type scenario is far less causally complex than the medical cases (with sick patients and much more going on) and it is hard to justify the onerous test applied in Broughton.

In *Rebelo (No1)* the Court of Appeal sought to assist the lower courts with a potential formulation as follows:

> 76. Thus, the jury had to be directed, first, that the defendant must owe the victim an existing duty of care which, secondly, has negligently been breached in circumstances, thirdly, that were truly exceptionally bad and so reprehensible as to justify the conclusion that it amounted to gross negligence and required criminal sanction. Fourth, the breach of that duty must be a substantial and operative cause of death, although not necessarily the sole cause of death. This last ingredient required further analysis which, without seeking to provide a definitive definition, could have been put to the jury in this way:

In relation to the question of causation, the prosecution must make you sure that the victim did not make a fully free, voluntary, and informed decision to risk death by taking the quantity of drug that she ingested. If she did make such a decision, or may have done so, her death flows from her decision and defendant only set the scene for her to make that decision. In those circumstances, he is not guilty of gross negligence manslaughter.

What does a fully informed and voluntary decision mean? Whether a decision is informed and voluntary will often be a question of degree. There are a range of

factors to be taken into account. The starting point will be the capacity of the victim to assess the risk and understand the consequences. Does he or she suffer from a mental illness such as to affect their capacity? In that regard, you will consider the evidence of Dr Rogers, remembering always that it is for you the jury to attach such weight as you feel appropriate to that expert evidence. Against the background of what you have concluded about her capacity, you will consider her ability to assess the risk and understand the consequences relating to the toxicity of the substance and her appreciation of the risk to her health or even her life by taking as much as she did and whether it eclipsed the defendant's grossly negligent breach of the duty of care.

In *Rebelo (No2)* the Court held that it had to be borne in mind that what was said by the Court of Appeal in the first appeal, as the court itself made plain, was suggestive only of the sort of direction that might be given; that it was not intended to be prescriptive. The breach of duty has to be a substantial and operative cause of death and the breach of duty would not be a cause of death if the deceased had or might have made a fully free, voluntary and informed decision, and the second paragraph expanded on the term "fully free, voluntary and informed" but the final sentence did not add an extra element to the requirement; that the expression "fully free, voluntary and informed" meant her "ability to assess the risk and understand the consequences relating to the toxicity of the substance and her appreciation of the risk to her health"; that what was required was a balancing exercise in order to decide whether the prosecution had established that a defendant's breach of duty was a substantial and operative cause of death, even if it was not the sole such cause; that, only if the deceased's decision to take the capsules was a fully free, voluntary and informed decision, or might have been, would her death, as a matter of law have been caused by her free choice because in those circumstances the defendant had only set the scene for her to make that decision, but he would not have caused her death.

Conclusion

A range of authorities were discussed in each of these appeals and the law is intended to be settled. However, leaving such complex issues as questions of fact in the huge range of circumstances in which it might be said that a person has failed to use reasonable care and skill puts numerous professionals at risk

of prosecution when dealing with vulnerable people, even ones they have never met. At the same time, the bracket for seemingly callous members of the public in drug related cases seems narrower. These are issues of liability which will continue to test trial advocates, judges, and juries for some significant time to come.