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GROSS NEGLIGENCE MANSLAUGHTER IN HEALTHCARE: TIME FOR A RESTORATIVE JUSTICE APPROACH?

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ABSTRACT

This paper explores the merits of employing a restorative justice approach in cases of gross negligence manslaughter (GNM) involving healthcare professionals, in line with the recent policy turn towards developing a just culture in addressing episodes of healthcare malpractice within the National Health Service (NHS) in England. It is argued that redress for victims and rehabilitation of offenders should operate as key values, underpinning the adoption of a restorative justice approach in such cases. It would also be vital that a structured pathway was designed that established suitable protocols and safeguards for both victims and offenders taking account of problematic issues such as the informality of the process, power asymmetries between parties, and the context in which the offence took place. Taking all such matters into account, we propose that consideration be given to establishing a pilot involving the use of restorative justice in cases of GNM involving healthcare professionals, which would be subject to judicial and stakeholder oversight to ensure transparency and accountability, which in turn could inform future policy options.

Keywords: doctors - gross negligence manslaughter - healthcare professionals - law reform - medical manslaughter - restorative justice

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I. INTRODUCTION

The prosecution of healthcare professionals and National Health Service (NHS) Trusts arising out of poor treatment resulting in the death of patients has attracted widespread media attention in England in recent years.[1] This has taken place in the context of a marked decline in deference towards the healthcare professions;[2] a growing catalogue of healthcare scandals;[3] and claims that the NHS is 'in crisis' due to unprecedented funding cuts.[4] There are now growing concerns on the part of healthcare professionals that they may unjustly face criminal prosecutions as a result of substandard care.[5] Such concerns have been heightened in the wake of recent convictions of healthcare professionals for gross negligence manslaughter (GNM),[6] and a fundamental loss of confidence in the regulator, the General Medical Council (GMC).

Compared to other common law jurisdictions, England presents as an outlier in its increasingly punitive approach to criminalising cases of fatal errors involving healthcare professionals.[7] These developments have fuelled academic and policy debates about the utility of employing the criminal

[1] See, for example, K Rawlinson, 'Optometrist Wins Appeal Against Conviction for Manslaughter of Boy, 8', The Guardian, 31 July 2017; BBC News, 'Southern Health NHS Trust Admits Guilt over Connor Sparrowhawk's Death', 18 September 2017; BBC News, 'Dr Hadiza Bawa-Garba: Struck-off Doctor Can Return to Work', 9 April 2019.
[2] J Miola, 'The Impact of the Loss of Deference Towards the Medical Profession' in A Alghrani, R Bennett and S Ost (eds), *The Criminal Law and Bioethical Conflict: Walking the Tightrope* (CUP 2012) 220-35.
[3] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, HC 947 (Chair: Mr Robert Francis QC) (TSO 2013); B Kirkup, The Report of the Morecambe Bay Investigation, March 2015 (TSO 2015); March 2020); Mazars Group, Independent Review of Deaths of People With a Learning Disability or Mental Health Problem in Contact with Southern Health NHS Foundation Trust April 2011 to March 2015, 16 December 2015; Gosport War Memorial Hospital: The Report of the Gosport Independent Panel, HC 1084, June 2018.
[4] 'Long-Term Plan for NHS England 'Undeliverable' Amid Staffing Crisis' The Guardian, 7 January 2019; S Neville, 'Funding Cuts to Prevention and Care Threaten NHS Vision' Financial Times, 18 June 2019.
[5] D Cohen, 'Back to Blame: the Bawa-Garba Case and the Patient Safety Agenda' (2017) 359 BMJ j5534; H Agerholm, 'Dr Bawa-Garba: Doctors Threaten to Boycott Their Appraisals Over Treatment of Trainee Paediatrician' The Independent, 1 February 2018; S Boseley, 'Medical Watchdog GMC Needs to Regain Trust of Doctors, Finds Review' The Guardian, 6 June 2019.
[6] Recent prosecutions of healthcare professionals include *R v Holtom* [2011] 1 Cr App R(S) 18; *Garg v R* [2012] EWCA 2520; *R v David; R v Barrass* [2012] 1 Cr.App.R (S) 80; *R v Rudling* [2016] EWCA Crim 741; *Sellu v R* [2016] EWCA Crim 1716l; *Bawa-Garba v R* [2016] EWCA Crim 1841; *Rose v R* [2017] EWCA Crim 1168.
[7] An examination of how and why England presents as an outlier in this regard is examined in more detail later in the paper.

law to regulate healthcare ethics and practice, particularly the use of the GNM offence. Concerns raised in such debates include how criminal investigations are conducted, the use of prosecutorial discretion and whether such prosecutions promote systems learning and patient safety.[8] In response to such concerns, it has been argued that the focus should instead be on conduct rather than outcome;[9] that healthcare professionals deserve special immunity from prosecution in light of the nature of the work they do;[10] and that a more rehabilitative approach should be taken in the case of negligence or mistakes on their part.[11]

More recently, reviews commissioned by the Department of Health (Williams Review) and the GMC (Hamilton Review) have called for the embedding of a more just culture in response to the criminalisation of cases of healthcare malpractice, in particular those involving GNM. The development of such a culture would involve 'systems, procedures and processes surrounding the criminal law and medical regulation being applied',[12] in circumstances where healthcare professionals would be able to learn 'without fear of retribution'.[13] At the same time, they would also be encouraged to admit to errors in such cases, while necessary steps would be taken to ensure that they, patients and their families were dealt with in a 'fair and compassionate manner'.[14] Both Reviews made a range of recommendations to support the development of such a culture. These

[8] O Quick, 'Prosecuting "Gross" Negligence: Manslaughter, Discretion and the Crown Prosecution Service' (2006) 33 J Law Soc 421; O Quick, 'Patient Safety and the Problem and Potential of Law' (2012) 69 CLJ 186.
[9] M Brazier and A Alghrani, 'Fatal Medical Malpractice and Criminal Liability' (2009) 25(2) PN 51.
[10] O Quick, 'Medical Killing: Need for a Specific Offence' in C Clarkson and S Cunningham (eds), *Criminal Liability for Non-Aggressive Death* (Ashgate 2008) 155-77.
[11] See, for example, J Montgomery, 'Medicalizing Crime – Criminalizing Health?' in C Erin and S Ost (eds), *The Criminal Justice System and Health Care* (OUP 2007) 263; A Merry and W Brookbanks, *Errors, Medicine and the Law* (2nd edn, CUP 2017).
[12] General Medical Council, *Independent Review of Gross Negligence Manslaughter and Culpable Homicide*, June 2019, 5 www.gmc-uk.org/-/media/documents/independent-review-of-gross-negligence-manslaughter-and-culpable-homicide---final-report_pd-78716610.pdf (accessed 31 March 2020) (Hamilton Review).
[13] Department of Health, *Gross Negligence Manslaughter in Healthcare: The Report of a Rapid Policy Review* (Department of Health 2018) para 3.4 (Williams Review).
[14] ibid para 2.1

included, inter alia, removing professional perceptions of arbitrariness and inconsistency in the conduct of police and prosecutorial investigations into alleged cases of GNM; promoting greater trust between doctors and the GMC through removing its right to appeal fitness to practice decisions; providing greater support to bereaved families through increased transparency of investigative processes; and engaging in professional and systems learning to prevent a reoccurrence of the events that led to the death of patients.[15]

The reference made in both Reviews to developing a just culture reflects a policy shift away from a no blame culture, which focuses primarily on systems learning arising from healthcare malpractice.[16] It is a shift that can be observed in recent expert, government and parliamentary reports in the area,[17] and in the publication by NHS Improvement of a structured pathway for implementing such a culture in healthcare settings.[18] Notwithstanding the growing prominence of the term in policy discourse, however, the parameters of what constitutes a just culture and how it should be applied in healthcare settings remains contested within the academic literature.[19] Advocates of the approach draw on restorative principles to argue that developing such a culture will create a fairer and more accountable culture with a view to improving quality and safety in healthcare settings.[20] This appears to have been translated into practice as an organisational process designed to improve patient safety, staff morale and cost savings through fairer and more

[15] ibid 5-6.
[16] S Dekker, *Just Culture: Restoring Trust and Accountability in Your Organization* (3rd edn, CRC Press, 2016) x-xiv.
[17] See, for example, Department of Health, Learning Not Blaming: The Government Response to the Freedom to Speak Up Consultation; House of Commons, the Public Administration Select Committee Report, Investigating Clinical Incidents in the NHS, and the Morecambe Bay Investigation, Cm 9113 (Department of Health 2015); Department of Health, Report of the Expert Advisory Group, Healthcare Safety Investigation Branch (Department of Health 2016).
[18] NHS Improvement, Just Culture Guide, https://improvement.nhs.uk/resources/just-culture-guide/ (accessed 31 March 2020).
[19] See for example, RM Wachter and PJ Provonost, 'Balancing "No Blame" with Accountability in Patient Safety' (2009) 361(14) NEJM 1401; S Dekker and N Leveson, 'The Systems Approach to Medicine: Controversy and Misconceptions' (2015) 24(7) BMJ Qual Saf 7.
[20] Dekker (n 16).

transparent management procedures within the NHS.[21] While laudable in intent, the concern is that it will remain a top-down reform that is largely responsive to institutional and professional needs, which operates in practice to marginalise the voices of patients and their families who have been harmed as a result of healthcare malpractice.

Drawing inspiration from these policy developments, what we wish to explore in this paper is how and why a restorative justice approach, with a normative focus on healing and righting wrongs as between victims and offenders, and making amends for harm caused, should be employed to address cases of GNM involving healthcare professionals.[22] While we note that general proposals have previously been put forward in this regard,[23] this paper seeks to elaborate upon the values and processes that should inform the adoption of the approach in practice. In relation to values, we argue that the principles of redress and rehabilitation should guide its use in such cases, in circumstances where an increased focus is placed on the voices and needs of victims.[24] In relation to process, we recognise the importance of developing a structured pathway for the use of a restorative justice approach in cases of GNM involving healthcare professionals, which may operate in a way that is complementary to the existing retributive model. Designing such a pathway would require that suitable protocols and safeguards are put in place for both victims and offenders

[21] See M Kaur, RJ de Boer, A Oates et al, 'Restorative Just Culture: A Study of the Practical and Economic Effects of Implementing Restorative Justice in an NHS Trust' (2019) 273 MATEC Web of Conferences 01007.
[22] As noted by J Braithwaite and C Parker, 'Restorative Justice is Republican Justice' in G Bazemore and L Walgrave (eds) *Restorative Juvenile Justice* (Criminal Justice Press 1999) pp. 109-10; J Braithwaite, 'Principles of Restorative Justice' in A von Hirsch et al (eds) *Restorative Justice and Criminal Justice: Competing or Reconcilable Paradigms?* (Hart 2003) 5.
[23] See A Sanders, 'Victims' Voices, Victims' interests, and Criminal Justice in the Healthcare Settings' in D Griffiths and A Sanders (eds), *Bioethics Medicine and the Criminal Law, Vol. 2, Medicine Crime and Society* (CUP 2013) 81.
[24] For the purposes of this paper, we recognise that there are both surrogate and direct victims of GNM offences. 'Surrogate victims' are bereaved families who have been relationally affected by the loss of a 'direct victim', namely a family member, as a result of a fatal error in healthcare provision. This is discussed in more detail later in the paper.

which take account of problematic issues which may arise in relation to informality, power asymmetries, and the context in which the offence took place.

In order to explore these arguments in more detail, we first review recent policy and legal developments in England with regard to criminalising healthcare malpractice, focusing on cases of GNM involving healthcare professionals. We then go on examine the reasons for the increasingly punitive approach being taken in England, making reference to how similar cases are dealt with in other common law jurisdictions. We then explore the merits of adopting a restorative justice approach, examining key values and processes that would guide its adoption in such cases. In the concluding section of the paper, we set out our proposal for establishing a pilot scheme which would employ a restorative justice approach in cases giving rise to GNM investigations/prosecutions involving healthcare professionals.

II. CRIMINALISING HEALTHCARE MALPRACTICE

A. Recent Developments under English law

There has long been a significant problem with negligent (or preventable) adverse events in the NHS.[25] In some instances, such events have resulted in serious injury or death to patients, at great emotional, physical and financial cost to their families. This is quite apart from the toll such events take on the healthcare professionals involved, whether they are primarily as a result of individual and/or system failures in the provision of healthcare.[26] In the absence of a clear intention to cause harm or death to patients, it is usually only in circumstances where there has been gross negligence

[25] For an historical overview, see Department of Health, An Organisation with a Memory: Report of an Expert Group on Learning from Adverse Events in the NHS (TSO 2000). See more generally, NHS Improvement, Patient Safety, https://improvement.nhs.uk/improvement-hub/patient-safety/ (accessed 31 March 2020).
[26] O Quick, 'Outing Medical Errors: Questions of Trust and Responsibility' (2006) 14 Med L Rev 22, 38-41; Merry and Brookbanks (n 11).

in the treatment of patients resulting in their death, that the criminal law is invoked under English law.[27] However, what constitutes the offence of GNM is far from clear or satisfactory and its vagueness has attracted criticism on the grounds that this area of law is 'something of a dog's breakfast' and an 'exhibition of the common law at its worst'.[28] The leading authority on GNM remains the House of Lords judgment in *R v Adomako,* where Lord Mackay explained that the test for gross negligence depends 'on the seriousness of the breach of duty committed by the defendant in all the circumstances in which the defendant was placed … [and] the extent to which the defendant's conduct departed from the proper standard of care incumbent upon him … was such that it should be judged criminal.'[29]

Unsurprisingly, the formulation was subsequently criticised for its circularity.[30] In principle, *Adomako* establishes that the test for gross negligence is wholly objective. In practice, what transforms 'simple negligence into its gross counterpart is far from clear.'[31] When explaining the test to juries, judges have used a range of terms including 'culpable', 'criminal', 'gross' and 'wicked'.[32] Ambiguity as to what constitutes 'gross' negligence in a given set of circumstances has meant that juries face a difficult task in determining whether a particular episode of substandard care on the part of a healthcare professional should be judged as criminal.[33] The Court of Appeal recently attempted to refine the *Adomako* test in the case of *Rose*,[34] setting out five elements the

[27] *R v Adomako* [1994] 3 UKHL 6 (30 June 1994).
[28] A Lodge, 'Gross Negligence Manslaughter on the Cusp: The Unprincipled Privileging of Harm over Culpability' (2017) 80(2) J Crim Law 125.
[29] *R v Adomako* (n 27) per Mackay LJ.
[30] Quick, (n 8); O Quick, 'Expert Evidence and Medical Manslaughter: Vagueness in Action' (2011) 38 J Law Soc 496.
[31] H Quirk, 'Sentencing White Coat Crime: The Need for Guidance in Medical Manslaughter Cases' (2013) 11 Crim L Rev 873.
[32] *R v Bateman* (1972) 19 Cr. App. R. 8 at [11].
[33] D Hubbeling, 'Criminal Prosecution for Medical Manslaughter' (2010) 103(6) J Royal Soc Med 216.
[34] *Rose v R* [2017] EWCA Crim 1168.

prosecution must prove in order for a defendant to be found guilty of GNM.[35] Notwithstanding this attempt at judicial clarity, the Court's approach has been criticised on the grounds that it has served to undermine the 'objective nature of the test set out in *Adomako*'.[36] As one commentator has ruefully observed, what appears to follow from the judgment is that unless 'wilful blindness' is demonstrated, 'even the most truly, exceptionally bad negligence resulting in ignorance will excuse one suspected of GNM'.[37]

In 2019, the Crown Prosecution Service (CPS) published legal guidance setting out its approach to GNM. It identified the type of conduct that would meet the 'evidential test for grossness', drawing on relevant case law to date. Examples noted in the guidance include where there was evidence of a course of conduct by an individual and a series of serious breaches; deliberately overriding or ignoring of systems which were designed to be safe and had proved to be safe; and ignoring warnings from others members of staff; or acting against the advice of other members of the team alerting them to serious dangers or risk. It was also emphasised that 'all relevant circumstances in which that individual was working' would be taken into account by prosecutors in assessing whether the conduct in question satisfied the test.[38] While the CPS guidance is to be welcomed, it is not clear it does much to bring greater clarity or certainty for healthcare professionals, or indeed any other individuals, charged with the GNM offence.

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[35] ibid [77] per Leveson P. These five elements are (a) the defendant owed an existing duty of care to the victim; (b) the defendant negligently breached that duty of care; (c) it was reasonably foreseeable that the breach of that duty gave rise to a serious and obvious risk of death; (d) the breach of that duty caused the death of the victim; and € the circumstances of the breach were truly exceptionally bad and so reprehensible as to justify the conclusion that it amounted to gross negligence and required criminal sanction.

[36] K Laird, Manslaughter: *R. v Rose (Honey Maria)* Court of Appeal (Criminal Division): Sir Brian Leveson PQBD, Haddon-Cave J and HH Judge Inman QC: 31 July 2017; [2017] EWCA Crim 1168' (2018) 1 Crim L Rev 76, 81.

[37] A Mullock, 'Gross Negligence (Medical) Manslaughter and the Puzzling Implications of Negligent Ignorance: *Rose v R* [2017] EWCA Crim 1168' (2018) 26(2) Med L Rev 346, 354.

[38] Crown Prosecution Service, Gross Negligence Manslaughter Legal Guidance, 14 March 2019 https://www.cps.gov.uk/legal-guidance/gross-negligence-manslaughter (accessed 31 March 2020).

In addition to persisting uncertainty as to type and range of negligent conduct that would satisfy the evidential test for grossness, sentences for healthcare professionals convicted of GNM have also increased in severity in recent decades. In the 1990s, a healthcare professional was likely to receive a six-month suspended sentence following such a conviction. This was exemplified in the case of Dr Adomako, notwithstanding the fact that his conduct was described as 'abysmal' and a 'gross dereliction of care'.[39] More recently, custodial sentences of greater length have increasingly been imposed. Examples include the case of Dr Garg, a consultant urologist, who received a three-year custodial sentence reduced to two years, following a GNM conviction in 2012.[40] This was followed in 2013 by the case of Dr Sellu, a colorectal surgeon, who received an initial two-and-a-half-year custodial sentence following a GNM conviction, for which he served fifteen months in prison, before his conviction was deemed unsafe and quashed on appeal.[41] Following the publication of an updated sentencing guideline for those convicted of GNM under English law in 2018, healthcare professionals will now face a minimum two to four year custodial sentence following a GNM conviction, with provision for this to be increased depending on the level of culpability involved.[42]

In lockstep with this shift towards harsher sentences following a GNM conviction, professional regulators also adopted an increasingly punitive, rather than rehabilitative, approach to dealing with healthcare professionals in the wake of such convictions. This was highlighted in the

[39] *R v* Adomako (n 27). See generally M Brazier and N Allen, 'Criminalizing Medical Negligence' in C Erin and S Ost (eds), *The Criminal Justice System and Health Care* (OUP 2007) 19.
[40] *Garg v R* (n 6).
[41] *Sellu v R* (n 6).
[42] The Sentencing Council for England and Wales, Manslaughter: Definitive Guideline, effective 1 November 2018, www.sentencingcouncil.org.uk/wp-content/uploads/Manslaughter-definitive-guideline-Web.pdf (accessed 31 March 2020).

contrasting approach taken by the GMC in the cases of *Garg* and *Bawa-Garba*. In the earlier case of *Garg* previously referred to, the GMC imposed a twelve-month suspension from practice following Dr Garg's release from serving a two-year custodial sentence for GNM.[43] In the more recent case of *Bawa-Garba*, the Medical Practitioners Tribunal Service (MPTS), which had been established in 2012 to provide a clear separation between the GMC's investigative and adjudicative functions, initially imposed a twelve-month suspension from medical practice.[44] In opting for a time-limited suspension from medical practice rather than erasure from the medical register, the MPTS found that 'in the circumstances of [Dr Bawa-Garba's] case, balancing the mitigating and aggravating factors … erasure would be disproportionate'.[45]

Subsequent to this decision by the MPTS, however, the GMC appealed to the High Court. The GMC argued that the MPTS was 'wrong' to allow Dr Bawa-Garba to continue to practise,[46] as a GNM conviction was evidence of the fact that her professional failings, which had resulted in the death of her patient, 'were truly exceptionally bad.'[47] In the leading judgment by Justice Ouseley, he agreed with the GMC, finding that the MPTS had failed to give the 'required' weight to the jury's verdict 'when considering the need to maintain public confidence in the profession and proper standards.'[48] In the circumstances, this required Dr Bawa-Garba's erasure from the register.[49] Subsequently, Dr Bawa-Garba successfully appealed this judgment to the Court of Appeal, which set it aside and restored the earlier decision of the MPTS. In doing so, the Court recognised that the MPTS was an expert body which had been satisfied on the evidence that the

[43] *Garg v R* (n 6). Dr Garg's suspension from medical practice is referred to in the findings of the MPTS, Determination in the Case of Dr Hadiza Bawa-Garba, 13 June 2017.
[44] Referred to in *General Medical Council v Bawa-Garba* [2018] EWHC 76 (Admin) at [19-24] per Ouseley J.
[45] ibid.
[46] ibid [25] per Ouseley J.
[47] ibid [38] per Ouseley LJ; [55] per Gross LJ.
[48] ibid [38] per Ouseley J.
[49] ibid [53-54].

risk of future harm to patients under her care was low, and on a par with other doctors of similar standing and experience.[50] Following this judgment, Dr Bawa-Garba's case again came before the MPTS in April 2019. Having reviewed all the evidence, the MPTS determined that a cumulative eighteen-month suspension from medical practice had served the public interest in the circumstances. In 2020, she would be permitted to return to medical practice subject to a two-year period of conditional registration, following the completion of which her case would return to the Tribunal for further review.[51]

As highlighted in the *Bawa-Garba* litigation, persisting concerns about the pursuit of GNM prosecutions against healthcare professionals in England have again called into question whether doctors (and healthcare professionals more generally) should receive some form of 'special immunity' from prosecution,[52] or indeed whether particular criminal offences should be created for healthcare professionals in circumstances involving (grossly) substandard care resulting in the injury or death of patients.[53] The traditional justification for special immunity in the case of healthcare professionals has been that they are undertaking socially vital work, often requiring rapid, high-risk decisions under pressured conditions. However, this is arguably the case for those working in a range of other occupations,[54] so it begs the question as to why healthcare professionals should be marked out as deserving of special immunity in the circumstances.

[50] *Bawa-Garba v General Medical Council & Ors* [2018] EWCA Civ 1879 at [93].
[51] MPTS, Record of Determination: Dr Hadiza Bawa-Garba, GMC Ref No. 6080659, 9/4/2019, paras 23, 27.
[52] See Brazier and Alghrani (n 9) 66.
[53] Quick (n 10) 158.
[54] See *R v Wacker* [2003] 1 Cr App R 329; *R v Holloway* [1993] 3 WLR 922; *R v Beckingham and Barrow Borough Council*. See generally, BBC News, 'Manslaughter Teacher Wins Appeal' 16 April 2002; G Forlin, 'Directing Minds: Caught In A Trap' (2004) 154 (7118) New Law Journal 326; BBC News, 'Four Guards Cleared Of Jail Death', 2 April 2007; D Conn, 'Hillsborough: David Duckenfield Found Not Guilty of Manslaughter' The Guardian, 28 November 2019.

While it is not possible to draw conclusions about the extent to which healthcare professionals are singled out in terms of GNM prosecutions involving professionals based on current data collection practices by the CPS,[55] it is nevertheless clear that fatal errors by healthcare professionals do attract a significant 'degree of publicity or public odium.'[56] As underlined by the Williams Review, they 'go to work to alleviate suffering not to add to it. They work in complex, high-risk environments, invariably as part of a team, and when things go wrong it is rarely the result of one individual's error.'[57] It is this particular combination of individual culpability, the performance of a valuable societal role and systems failures which means that the criminalisation of healthcare malpractice through the use of the GNM offence continues to present formidable challenges for prosecutorial authorities,[58] no doubt contributing to variation in decision-making with regards to pursuing GNM prosecutions.[59]

In the case of Dr Bawa-Garba, systems failures were recognised as contributing factors leading to substandard care, resulting in the death of her patient. These failures included poor training, particularly in relation to overseas qualified doctors; staff shortages; long working hours leading to exhaustion and poor judgement; and a lack of adherence to appropriate clinical governance standards.[60] Notwithstanding recognition of the role often played by systems failures in contributing to substandard care towards patients, there has been little success to date in prosecuting NHS Trusts under health and safety or corporate manslaughter legislation in relation

[55] While the CPS have estimated that they receive approximately 200 referrals a year nationally, the CPS does not routinely collect data on GNM prosecutions (Williams Review (n 13) 11).
[56] Brazier and Alghrani (n 9).
[57] Williams Review (n 13) 5.
[58] Quirk (n 31) 873.
[59] J Samanta and A Samanta, 'Gross Negligence Manslaughter and the Delivery of Healthcare: A Time for Change?' (2019) 26(5) Eur J Health Law 389.
[60] The role played by 'multiple systemic failures' leading to substandard care on the part of Dr Bawa-Garba was recognised by the MPTS in its initial determination on impairment (MPTS, (n 44)), and was referred to in *GMC v Bawa-Garba* (n 44) [28] per Ouseley J.

to inadequate supervision and poor management of doctors contributing to the death of patients.[61] The legislative extension of the offence of wilful neglect to encompass care workers and care providers involved in the provision of health care and social care was expected to lead to an increased rate of (successful) prosecutions against healthcare professionals, but this has also not eventuated to date.[62] This is to be contrasted with the increasingly punitive approach taken to criminalising fatal errors by individual healthcare professionals through the use of the GNM offence, which we now turn to examine in more detail in the next section of the paper.

B. England as an Outlier: an Increasingly Punitive Approach

As highlighted in the previous section, there appears to be an increasingly punitive approach taken to healthcare professionals following a GNM conviction. In the wake of the *Bawa-Garba* litigation, doctors have been particularly vocal in expressing their concerns about their vulnerability to GNM investigations and/or prosecutions where inadvertent errors on their part may have contributed to the death of patients under their care. As the Hamilton Review observed, doctors recognised Dr Bawa-Garba's situation in their own working lives, neatly summed up in the phrase: 'there but for the grace of God, go I.'[63] Healthcare professionals perceive that such prosecutions are on the rise, alongside a more punitive approach to sanctions on the part of the courts and professional regulators in the event of conviction. Such perceptions have served to create a climate of 'toxic

[61] C Dyer, 'Hospital Trusts Prosecuted for Not Supervising Junior Doctors' (2006) 332 BMJ 135. For a successful prosecution of another NHS Hospital Trust under health and safety legislation, see the case of Mayra Cabrera who died following the injection into her arm of an epidural drug, Bupivacaine, Unknown Author, 'Court Date Set for Epidural Death Case' *Swindon Advertiser*, 28 December 2009. In relation to corporate manslaughter prosecutions, there has only been one successful prosecution to date, see *R v Cornish and another* [2016] EWHC 779 (QB). The lack of successful prosecutions has been attributed to difficulties in establishing 'a direct causal link between high level policy decisions and the death of an individual patient' (Hamilton Review (n 12) para 76).

[62] Criminal Justice and Courts Act 2015, ss 20-25. It had been estimated that there would be at least 240 prosecutions per annum following this new offence coming into force (Department of Health, Impact Assessment, Criminal Offence of ill-Treatment or Wilful Neglect, 10 June 2014). However, our review suggests there has only been one unsuccessful prosecution to date, with a retrial pending at the time of writing, see Editorial Correspondent, 'Nurse Accused of Neglect at Care Home to Stand Trial Again', Rugby Observer, 7 December 2019.

[63] Hamilton Review (n 12) 3.

fear' for many healthcare professionals, which it is argued is not conducive to providing good and safe healthcare in the NHS.[64] Yet how do such perceptions match with reality? In this regard, interpreting what data is available has been problematic. This is attributable both to the relative rarity of such cases and the fact that there is currently no centralised or systematic approach to data collection on GNM investigations and prosecutions in England.[65]

An earlier study by Ferner and McDowell showed that there had been a substantial increase in the rate of GNM prosecutions against healthcare professionals from 1990 onwards, although conviction rates remained low.[66] More up-to-date analysis shows that since the *Adomako* case twenty-five years ago, the deaths of 38 patients have led to GNM prosecutions of 47 healthcare professionals (37 doctors, 9 nurses and 1 optometrist). This has resulted in 23 convictions, with 4 subsequently being overturned on appeal. In recent years though, there has been a marked decline in obtaining successful convictions. Since 2013, GNM prosecutions brought against 15 healthcare professionals resulted in only 6 convictions, of which 2 were subsequently overturned on appeal.[67] A recently published review of a sample of CPS files by Griffiths and Quick showed that there were 192 GNM investigations referred to the CPS between 2007 and 2018. There was a noticeable increase in the years 2011 to 2017, which they attributed to greater awareness on the part of the police regarding the need to refer such cases to the CPS, alongside better recordkeeping in such cases on the part of both the police and the CPS. Despite such increase, however, it had only resulted in 12 prosecutions, representing 6% of the total number of referrals. Apart from a spike

[64] See M Brazier and others, 'Improving Healthcare Through the Use of 'Medical Manslaughter'? Facts, Fears and the Future' (2017) 22(6) J Patient Safety Risk Management 88.
[65] D Griffiths and O Quick, 'Managing Medical Manslaughter Cases: Improving Efficiency and Transparency?' University of Bristol Law Research Paper Series, May 2019, 2-3, 6-8.
[66] RE Ferner and SE McDowell, 'Doctors Charged with Manslaughter in the Course of Medical Practice, 1795–2005: A Literature Review' (2006) 99(6) J Royal Soc Med 309; Quirk (n 31).
[67] Williams Review (n 13) paras 4.5-4.6.

observed in 2014, they noted that the rate of GNM prosecutions against healthcare professionals in the sample reviewed remained relatively stable at one per year during this period.[68]

Although the rate of GNM convictions against healthcare professionals remains relatively low overall, the increased rate of investigations and prosecutions in England against healthcare professionals arising from the death of patients, stands in stark contrast to the approach taken in Scotland and in other common law jurisdictions. In Scotland, no offence for GNM exists. Instead, the closest offence which would be applicable in the case of the death of a patient would be involuntary culpable homicide. However, a total indifference or reckless disregard for the potential dangers and consequences would be required to satisfy the *mens rea* element of the offence. Mere carelessness or negligence is not enough. In light of this threshold, there have been no convictions to date involving healthcare professionals for this offence.[69]

In NZ, for example, there was an upsurge in the prosecutions of healthcare professionals for manslaughter arising out of the death of their patients in the closing decades of the twentieth century, facilitated by the fact that prosecutors only needed to meet a legislative test for ordinary (rather than gross) negligence.[70] In the wake of growing concerns by NZ healthcare professionals, legislative reform was subsequently enacted to change the threshold requirement from an ordinary to a gross negligence test.[71] This was followed by other reforms which established independent

[68] Griffiths and Quick (n 65) 25.
[69] Hamilton Review (n 12) para 39; General Medical Council, Report of the Task and Finish Group on Context of the Healthcare System in Scotland and Scottish Law Relating to Culpable Homicide, June 2019, paras 28-29 https://www.gmc-uk.org/-/media/documents/report-of-the-task-and-finish-group-on-context-of-the-healthcare-system-in-scotland-and-sco-78716616.pdf (accessed 31 March 2020).
[70] PDG Skegg, 'Criminal Prosecutions of Health Professionals: The New Zealand Experience' (1998) 6(2) Med L Rev 220. See generally Crimes Act 1961 (Public Act 1961 No 43), ss 155 and 156 [reprint as at 24 March 2020].
[71] ibid Crimes Act 1961, s 150A(2); A McCall Smith and A Merry, 'Medical Accountability and the Criminal Law: New Zealand vs the World' (1995) 3 Health Care Anal 140; Skegg (n 70) 235.

mechanisms for investigations of patient complaints and a focus on rehabilitation of healthcare professionals where harm was caused to patients as a result of substandard care. Following these reforms, there has been a steep decline in such prosecutions, with only one unsuccessful one in the past decade.[72]

In both Canada and Australia, prosecutions alleging criminal negligence involving healthcare professionals arising from the deaths of their patients are rarely pursued; where they are, there has been little success in obtaining convictions. In Canada, for example, only 14 healthcare professionals were charged with the offences of criminal negligence causing death or grievous bodily injury in relation to harm or death to patients between 1900 and 2007, resulting in one successful conviction.[73] Since 1990, no doctor has been charged with manslaughter arising from the death of a patient. This was attributed by one commentator to difficulties in meeting evidentiary threshold requirements, in addition to Canadian prosecutors being reluctant to take an 'aggressive' approach towards doctors in response to fatal errors, in contrast to the *Bawa-Garba* litigation in England.[74] In Australia, there have been just over 30 GNM prosecutions (predominantly involving doctors) since the 1830s. Very few have been successful, with numerous instances of charges being withdrawn and prosecutions not proceeding to trial, in addition to multiple acquittals.[75] Indeed, the recent high profile *Patel* litigation highlighted the continuing difficulties faced by prosecutorial

[72] See R Ameratunga and others, 'Criminalisation of Unintentional Error in Healthcare in the UK: A Perspective from New Zealand' (2019) 364 BMJ l706.
[73] F McDonald, 'The Criminalisation of Medical Mistakes in Canada: A Review' (2008) 16 Health Law Journal 1, 13-16.
[74] W Glauser, 'Should Medical Errors Ever Be Considered Criminal Offences?' (2018) 23(190) CMAJ E518-9.
[75] D Carter, 'Correcting the Record: Australian Prosecutions for Manslaughter in the Medical Context' (2015) 22(3) JLM 588.

authorities in obtaining GNM convictions against healthcare professionals in the Australian context.[76]

When compared to other common law jurisdictions, England presents as an outlier in its increasingly punitive approach to criminalising cases of fatal errors involving healthcare professionals. This is particularly troubling, given that healthcare professionals found to be engaging in substandard performance resulting in fatal errors do not operate in a vacuum; instead, their working lives are embedded within institutional practices of the NHS which may contribute or otherwise exacerbate the circumstances in which such errors occur. This begs the question as to what ends this increasingly punitive approach is directed? Clearly, there are circumstances in which invoking the criminal law is appropriate where there is a clear intention to harm the patient, and where a healthcare professional is otherwise reckless in their provision of treatment or engages in wilful neglect of their patient.[77] Where there is a fatal error on the part of individual healthcare professionals, there is little in the way of empirical evidence to show that invoking the criminal law effectively deters such conduct, particularly where it takes place in complex and increasingly under-resourced healthcare environments, as was highlighted in the *Bawa-Garba* case. While the Williams and Hamilton Reviews acknowledge this to be the case, their recommendations reveal a largely top-down approach to reform in the area, which is focused on implementing reforms to

[76] It was alleged that Patel, a surgeon, had provided substandard care resulting in injury and/or death of at least 13 patients. Initially convicted on three counts of manslaughter and one count of grievous bodily harm, Patel was sentenced to seven years' imprisonment. On appeal, the convictions were quashed and a retrial was ordered, resulting in an acquittal on all charges. Eventually, a deal was reached which involved Patel pleading guilty to fraud, resulting in a two-year suspended sentence. Subsequent professional disciplinary proceedings resulted in permanent deregistration from practising medicine in Australia, see See *R v Patel* (2010) 202 A Crim R 53; [2010] QSC 198; *R v Patel* (2010) 202 A Crim R 60; [2010] QSC 199; *R v Patel* [2010] QSC 233; *R v Patel; Ex parte Attorney-General (Qld)* [2011] QCA 81; *Patel v The Queen* [2012] HCA 29; *R v Patel* [2013] QDC 21/11/2013; *Medical Board of Australia v Patel* [2015] QCAT 133 (HPF001-05).

[77] See K Yeung and J Horder, 'How Can the Criminal Law Support the Provision of Quality in Healthcare? (2014) 23(6) BMJ Quality and Safety 519, 522.

promote enhanced institutional transparency and professional accountability. While it is recognised that more could be done to provide relevant information to bereaved families, we consider that insufficient attention has been paid in both Reviews to the importance of giving voice to their needs, as well as providing suitable redress for harm caused.

We therefore question whether the Reviews' recommendations will in fact contribute to the development of a just culture in addressing healthcare malpractice in the NHS, particularly where it has resulted from fatal errors on the part of healthcare professionals. It is for this reason that we advocate for the adoption of a restorative justice approach in addressing such cases, which we argue offers the opportunity to fully embed a just culture that takes better account of the needs of victims, in addition to being responsive to the concerns of both healthcare professionals and institutions. In the following sections of the paper, we first examine how best to position the use of a restorative justice approach in the context of the current retributive model, before going on to explore the values and processes that should underpin its translation into practice in cases of GNM involving healthcare professionals.

III. RESTORATIVE JUSTICE AND HEALTHCARE MALPRACTICE

The increasingly punitive turn towards addressing cases of healthcare malpractice in England could be said to be multi-factorial and include the end of public, political and judicial deference towards the healthcare professions, particularly in the wake of successive healthcare scandals in recent years;[78] greater media interest and public condemnation of patient deaths resulting from medical treatment;[79] a greater preparedness on the part of the police/coroners to investigate patient deaths

[78] Lord Woolf, 'Are the Courts Excessively Deferential to the Medical Profession?' (2001) Med L Rev 1; Miola (n 2) 227.
[79] See (n 1).

caused through medical error; and for prosecutors to pursue such cases.[80] What is equally clear is that it is an approach which sits firmly within the retributive model of justice. Before considering whether a restorative justice approach might offer an alternative or complementary way forward, it is important to situate this approach within a broader socio-historical context in which such cases have become criminalised in line with this model.[81]

In determining criminal responsibility, it has been argued that there has been a conceptual shift over time under English law from a focus on defective character to one that is grounded in more liberalist assumptions of rationality.[82] More recently, it has been suggested that a further such shift has taken place which focuses primarily on the fact that harm has been caused.[83] The criminalisation of healthcare professionals in circumstances where there has been gross negligence sits uneasily with the first two conceptions but not the third, particularly where the death of a patient has occurred. Instead, this conception fits more easily with the regulatory function performed by the criminal law, as part of its interaction with other normative systems within the broader social order.[84] The question of legitimacy looms large in such circumstances. This is particularly so where criminalisation serves an important symbolic function,[85] highlighting the fact that such conduct is neither morally nor socially acceptable.

[80] Hamilton Review (n 12), chs 5-7.
[81] A Norrie, *Crime Reason and History* (3rd edn, CUP 2014) 19-38.
[82] ibid 20-4.
[83] N Lacey, 'The Rule of Law and the Political Economy of Criminalisation: An Agenda for Research' (2013) 15 Punishment & Society 351, drawing on T Honoré, 'Responsibility and Luck: The Moral Basis of Strict Liability' (1988) 104 LQR 530.
[84] N Lacey, 'Criminalisation as Regulation: The Role of the Criminal Law' in C Parker and others (eds), *Regulating Law* (OUP 2004) ch 7.
[85] ibid 157; See generally J Horder, *Ashworth's Principles of Criminal Law* (9th edn, OUP 2019).

If culpability if the main justification for those in favour of a retributive approach, the question is then raised as to why this proverbial line in the sand has been drawn in English law only where conduct deemed to be grossly negligent has resulted in the death of a patient? Why should a healthcare professional who inflicts grossly negligent harm on a patient short of death not attract criminal sanction? This state of affairs has attracted criticism on the grounds of moral relativism, with the focus on outcome rather than conduct in terms of determining engagement with the criminal process.[86] A corollary of this argument has also been to question exactly what sort of conduct justifies criminalisation in this situation. As has been previously highlighted under English case law to date, much of the judicial pronouncements on this point have involved a degree of circularity in reasoning which in turn has created difficulties in obtaining and presenting expert and other evidence to the court as to why conduct on the part of a particular healthcare professional should be considered so grossly negligent so as to justify a GNM conviction.[87] However, the broader issue at stake is whether negligence by healthcare professionals in the treatment of patients, be it gross or ordinary, should come within the criminal jurisdiction at all.[88]

One of the overarching aims of the criminal law is deterrence but can negligence be deterred? If deterrence is to be effective, it has been argued that the offender should be aware of the relevant law and able to analyse the costs and benefits of the crime, as opposed to compliance.[89] As noted previously, there is little in the way of evidence to indicate prosecutions for GNM under English law have achieved this objective.[90] A telling example is provided by the multiple instances in which

[86] Brazier and Alghrani (n 9) 67.
[87] Quick (n 8).
[88] Montgomery (n 11); S Ost, 'Drs Bramhall and Bawa-Garba and the Rightful Domain of the Criminal Law' J Med Ethics Blog, 23 December 2018, https://blogs.bmj.com/medical-ethics/2018/12/23/when-should-a-doctors-behaviour-be-criminal/ (accessed 31 March 2020).
[89] J Hall, 'Negligent Behaviour Should be Excluded from Penal Liability' (1963) 63 Columbia L Rev 641-2; PH Robinson, 'Does Criminal Law Deter? A Behavioural Science Investigation' (2004) 24 OJLS 173.
[90] A point noted in the Hamilton Review (n 12) para 160.

the drug Vincristine has been incorrectly administered to patients, resulting in their deaths. Notwithstanding a number of healthcare professionals being prosecuted for GNM as a result of such deaths,[91] it did not subsequently deter other healthcare professionals from making the same mistake with the same tragic consequences.[92] As one inquiry found, these episodes of substandard care by healthcare professionals had involved a 'complex amalgam of human error, technical and social interactions'.[93] Notwithstanding the importance of the criminal law's symbolic or expressive function in cases of serious or unacceptable ill-treatment of patients,[94] it is a less than compelling justification where such malpractice results from inadvertent error as opposed to deliberate wrongdoing, and in the absence of *mens rea*.[95] This leads us to question not only whether traditional theories of deterrence apply in cases of (gross) negligence involving healthcare professionals, but also whether criminalisation of such professionals based solely on a retributive model is useful in terms of enhancing quality and safety in healthcare more generally.

A. Restorative Justice and Gross Negligence Manslaughter Cases involving Healthcare Professionals

In this section of the paper, we examine how a restorative justice approach might work in cases of GNM involving healthcare professionals. In doing so, we wish to be clear that we do not see it as an either/or commitment, and that the use of such an approach should be seen as complementary to the current retributive model.[96] Given the gravity of the consequences which give rise to such

[91] *R v Prentice; R v Sullman* [1994] QB 302.
[92] J Holbrook 'The Criminalisation of Fatal Medical Mistakes' (2003) 327 BMJ 1118.
[93] B Toft, Department of Health External Inquiry into the Adverse Incident that Occurred at Queen's Medical Centre, Nottingham, 4 January 2001, 40.
[94] Yeung and Horder (n 77) 520-21.
[95] Merry and Brookbanks (n 11).
[96] As to whether restorative justice should be seen as an alternative to the retributive model, see K Daly, 'Revisiting the Relationship between Retributive and Restorative Justice' in H Strang and J Braithwaite (eds) *Restorative Justice: From Philosophy to Practice* (Ashgate 2000) 33; S Miller and J Blacker, 'Restorative Justice: Retribution, Confession and Shame' in H Strang and J Braithwaite (eds) *Restorative Justice: Philosophy to Practice* (Ashgate 2000) 77.

cases, it may indeed be more appropriate that it operates in this way. Indeed, such programs have often operated as an adjunct to more established retributive approaches, aimed at punishment and deterrence[97]. In addition, findings from empirical research arising from restorative justice programmes have shown that they often combine retributive, restorative and rehabilitative elements, which may be influenced by participants' differing understandings of punishment, retribution and punitiveness.[98] In the circumstances, we need to be mindful of the fact that this type of variation might also be seen in the reactions of victims (deceased patients' families) and offenders (healthcare professionals) in the context of employing a restorative justice approach in GNM cases.

In proposing a restorative justice approach, we acknowledge that how to define the term has been much debated within the relevant literature.[99] For present purposes, while we accept that a precise definition is likely to remain contested, we would adopt Daly's view that it operates as a justice mechanism, rather than a particular type of justice on its own.[100] We also acknowledge that the merits or otherwise of employing such an approach remain contested. For commentators such as Braithwaite, it has been argued that an expansive approach should be taken to how and where it should be used grounded in a normative justification that it is likely to promote healing, community and equality.[101] In contrast, we note the caution shown by commentators such as Ashworth in considering which matters should come within the remit of such an approach, taking into account the state's overarching responsibilities regarding the type of punishment and the protection of the

[97] Daly (n 96) 31-33.
[98] K Daly, 'Restorative Justice: The Real Story' (2002) 4(1) Punishment and Society 55, 59-61.
[99] See also H Zehr and H Mika, 'Fundamental Concepts of Restorative Justice' (1998) 1 Contemporary Justice Review 47; J Braithwaite and H Strang, 'Connecting Philosophy and Practice' in H Strang and J Braithwaite (eds) *Restorative Justice: Philosophy to Practice* (Ashgate 2000) 203-220.
[100] K Daly, 'What is Restorative Justice? Fresh Answers to a Vexed Question' (2016) 11(1) Victims and Offenders: An International Journal of Evidence-Based Research, Policy, and Practice 9.
[101] See Braithwaite and Parker (n 22) 104-107; cf. Miller and Blacker (n 103).

public interest.[102] Such caution also extends to claims made as to the success of restorative justice schemes in facilitating the reintegration of offenders, given the mixed findings from empirical research, with success or failure turning on the type of offender, the nature of the crime committed and the responsiveness of victims to the process.[103]

Nevertheless, our reasons for proposing a restorative justice approach in cases of GNM involving healthcare professionals include the fact that it offers a much more holistic approach to healing, as well as righting wrongs, that have occurred as between parties as a result of fatal errors by healthcare professionals. This is particularly so, given the range of moral obligations and responsibilities that underpin patient-doctors relations, and which also extend to bereaved families in the event of the death of loved ones due to such errors.[104] Other reasons to support such an approach include the fact that these cases arise in the context of fatal errors which involve no deliberate wrongdoing; are interwoven with systemic failures in healthcare environments; and occur in circumstances where there is a paucity of evidence of a deterrent effect. Added to this is the complexity and inconsistency in investigative and prosecutorial approaches, as well as continuing problems in accessing and employing of expert evidence in such cases.[105] Taking all such matters into account, we now turn to consider the key values and processes that should guide the use of a restorative justice approach in such cases.

[102] A Ashworth, 'Responsibilities, Rights and Restorative Justice' (2002) 42(3) Brit J Crim 578, 584-5.
[103] Daly (n 96); D Roche, 'Gluttons for Restorative Justice' (2003) 32(4) Economy and Society 631, 632.
[104] P Vines, 'The Value of Apologising within a Moral Community: Making Apologies Work' (2017) 7(3) Oñati Socio-legal Series [online] 370, 380-81.
[105] See generally Quick (n 8); Griffiths and Quick (n 65) 19-20, 24.

1. Values

In terms of values, the focus in restorative justice is on healing and righting wrongs as between victims and offenders, as well as finding ways to make amends for the harm suffered as a result of the offence. It also involves recognising that a range of persons (i.e. individuals, family/supporters and communities) may have been relationally affected by the offence that has been committed.[106] Such persons may include 'direct victims' being individuals directly harmed by the offence committed; and 'surrogate victims' being individuals who may have been adversely affected in some way as a result of the offence. This would include families of the direct victim.[107] For present purposes, such families would be recognised as victims for the purposes employing a restorative approach in the cases of GNM involving healthcare professionals, being relationally affected by the harm suffered by their family member as result of the offence.

We would propose that the key values that should underpin such an approach in these cases are *redress* to victims (bereaved families) and *rehabilitation* of offenders (healthcare professionals).[108] Our preferred use of the term 'redress' reflects its common usage in cases of negligence brought in the civil jurisdiction by individuals against healthcare professionals and institutions alleging harm suffered as a result of treatment in healthcare settings. In this context, redress is said to encompass payment of financial compensation, explanations, apologies, professional accountability and systems learning to prevent the harm from occurring again.[109] Redress schemes

[106] DW Ness and KH Strong, *Restoring Justice: An Introduction to Restorative Justice,* (5th edn, Routledge 2014) 43-60.
[107] A Saulnier and D Sivasubramaniam, 'Effects of Victim Presence and Coercion in Restorative Justice: An Experimental Paradigm' (2015) 39(4) Law and Human Behavior 378, 379-80.
[108] Both values are recognised as important in the restorative justice literature more generally, see Roche (n 103).
[109] C Vincent, A Phillips and M Young, 'Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action', (1994) 343 (8913) Lancet 1609; F Stephen, A Melville and T Krause, *A Study of Medical Negligence Claiming in Scotland*, Research Findings, No. 113/2012 (Government Social Research 2012).

of this type already exist in Wales,[110] with existing legislation available to do likewise in England.[111] This mirrors to a large extent the way in which the term 'reparation' has been understood within the restorative justice literature, where it has been described as involving payment of financial compensation by offenders for expenses incurred and wages lost by victims, state-sponsored systems of redress and the provision of practical, informational and emotional support for victims.[112] In the case of survivors of institutional sexual abuse, for example, it has been suggested that state-sponsored reparation schemes should include an apology or statement of regret; publishing details of the steps taken to prevent abuse in the future; and the provision of psychological care and financial compensation.[113]

It has also been recognised within this literature that there are limits to what should come within the remit of reparation in the criminal jurisdiction.[114] While victims may have a legitimate interest in matters of compensation, it has been argued the overarching focus remains on state responsibility for ensuring that offenders are punished for the crime committed, as well as determining the form or duration of punishment for such offenders, taking into account questions of proportionality and the public interest more generally.[115] It is a position which largely reflects the approach which currently operates in cases of GNM involving healthcare professionals in England. On one view, the concept of redress would therefore appear to have limited translational value in the existing

[110] The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, No. 704 (W. 108). See AL Ferguson and E Braithwaite, 'Putting Things Right in Wales' (2012) 18 Clinical Risk 6.
[111] NHS Redress Act 2006, c. 44. See AM Farrell and S Devaney, Making Amends or Making Things Worse? Clinical Negligence Reform and Patient Redress in England' (2007) 27(4) LS 630.
[112] G Johnstone, *Restorative Justice: Ideas, Values, Debates* (Willan Publishing 2002) 81.
[113] In the case of reparation arising from institutional sexual abuse, see E Catterall et al, *Apologies and Institutional Child Abuse, Apologies, Abuses & Dealing with the Past* (ESRC-funded project), September 2018, https://apologies-abuses-past.org.uk/assets/uploads/Apologies-Institutional-Abuse-Report_Sept-2018.pdf (accessed 31 March 2020).
[114] This may also involve a recognition that there are limits regarding the extent to which a victim's harm can be repaired see Roche (n 103) 632; Johnstone (n 112) 104.
[115] Ashworth (n 102) 581-2.

retributive model in which such cases are pursued in England, apart from the payment of financial compensation to victims under the Criminal Injuries Compensation Scheme.[116]

While accepting the parameters of this civil-criminal divide in the English jurisdiction, there appears to be an implicit assumption on the part of policy-makers, which is largely echoed in the Williams and Hamilton Reviews, that information disclosure about the conduct of GNM cases involving healthcare professionals will (or indeed should) on its own satisfy bereaved families in terms of providing redress for harm caused by the offence. However, our proposal for the adoption of a restorative justice approach challenges this viewpoint, in particular its narrow conception of the needs of victims in these circumstances. Adopting such an approach in cases of GNM involving healthcare professionals would instead allow for the development of a broader concept of redress which is normatively grounded in the promotion of healing and making amends for the wrongs suffered by victims as a result of the offence committed. In practical terms, it would encompass financial compensation, explanations, apologies, the provision of psychological care, systems learning to prevent a reoccurrence of the harm, and an acceptance of institutional accountability and/or state responsibility (as appropriate).

We now turn to consider the second key value which we have argued should underpin a restorative justice approach – namely, rehabilitation. In general terms, the question of whether such an approach could be said to promote rehabilitation of offenders remains contested in the relevant literature.[117] While an in-depth examination of these debates is outside the scope of this paper, we

[116] Criminal Injuries Compensation Scheme, www.gov.uk/government/publications/criminal-injuries-compensation-scheme-2012 (accessed 31 March 2020). 'Surrogate victims' such as bereaved families equate to 'qualifying relatives' (para 59) who are eligible to make a claim under the Scheme.

[117] See for example, A Morris, 'Critiquing the Critics: A Brief Response to Critics of Restorative Justice' (2002) 42 Brit J Crim 596; T Ward, KJ Fox and M Garber, 'Restorative Justice, Offender Rehabilitation and Desistance' (2014) 2(1) Restorative Justice 24.

do recognise the need to be cautious in simply equating the use of restorative justice processes with rehabilitation, in the absence of taking into account how risk and other social factors impact upon rehabilitation of offenders.[118] Nevertheless, we proceed here on the basis that in cases of fatal error by healthcare professionals giving rise to GNM investigations/prosecutions, such professionals show a commitment towards rehabilitation and a return to professional practice. In the circumstances, how should we understand rehabilitation as a key value underpinning the use of a restorative justice approach in this context?

First, it would necessarily include a preparedness to admit error on the part of the healthcare professional in question, together with a statement of regret/apology towards bereaved families. Second, the healthcare professional would be required to submit to a determination of fitness to practice, as well as ongoing review in the event that a favourable determination about a return to practice was made by a suitable independent body. Third, a focus on rehabilitation would serve to create an environment in which the mix of systemic failures and individual substandard performance that often feeds into fatal errors could be more readily acknowledged as between patients/families and healthcare professionals, the NHS, professional regulators and the courts. In turn, this would assist not only with reviews into the individual healthcare professional's fitness to return to practice, but also facilitate systems learning with a view to preventing a reoccurrence of the fatal error in question. Fourth, it would also mean that there could be pro-active and timely stakeholder engagement with these types of rehabilitative practices rather than having them put on hold, often for lengthy periods, while GNM investigations and prosecutions proceed, as is currently the case.

[118] For a recent overview in the criminology literature examining rehabilitation of offenders, see M Rocque, *Desistance from Crime: Bew Advances in Theory and Research* (Springer 2017).

As highlighted by the case of Dr Bawa-Garba, rehabilitation is clearly the preferred approach of bodies such as the MPTS where there has been a fatal error by a healthcare professional which is interwoven with systemic failures in healthcare environments. However, a reorientation is required in favour of such an approach on the part of the GMC. As both the Williams and Hamilton Reviews have highlighted, the increasingly punitive approach by the GMC with respect to doctors' fitness to practice following GNM convictions, has bred deep distrust on the part of the medical profession towards the GMC.[119] In the wake of such Reviews, the GMC has acknowledged regulatory overreach and conceded it should forfeit its right to appeal MPTS decisions.[120] In addition, it has committed to engaging constructively in the rehabilitation of doctors following fatal errors in healthcare provision. While this is a welcome development, it remains to be seen whether the GMC will regain the medical profession's trust, given its regulatory approach to date.

Inspiration for the adoption of (elements of) restorative justice approach arising from fatal error by healthcare professionals can be drawn from the approach taken in NZ. As noted earlier in the paper, a range of institutional and legislative reforms were implemented following a series of prosecutions against healthcare professionals arising from the death of patients, in addition to a major healthcare scandal which caused harm and death to multiple patients. As a result of such reforms, the independent office of the Health and Disability Commissioner (HDC) was created which established a centralised system for investigating and adjudicating on patient complaints for the first time. Through this process, patients' concerns regarding the need for accurate information disclosure and explanations were addressed, underpinned by the conduct of independent

[119] Williams Review (n 13) 6; Hamilton Review (n 12) para 188, rec 2.
[120] GMC Statement Following the Publication of the Independent Review of Gross Negligence Manslaughter and Culpable Homicide in Medical Practice, 6 June 2019 www.gmc-uk.org/-/media/documents/gmc-media-statement-in-response-to-indepedent-review-of-gross-negligence-manslaughter-and-c-78720869.pdf (accessed 31 March 2020).

investigations into what had happened. The outcomes from such investigations fed into systems learning and disciplinary processes involving healthcare professionals, the latter focusing on rehabilitation and reintegration into practice.[121] Access to financial compensation was provided to victims under NZ's national no-fault compensation scheme for accidental injury. A more joined-up approach, focused on redress and rehabilitation in cases of healthcare malpractice, also coincided with a dramatic reduction in prosecutions against healthcare professionals arising from fatal errors.[122]

2. Process

The process by which the values underpinning a restorative justice approach is implemented has long been recognised as vital to its success. In general terms, this requires that victims consent to be engaged in the process. In the case of offenders, there needs to be a preparedness to engage in, and be compliant with, the outcomes of the process. This takes place within an environment in which the process is a forward-looking focus in terms of focusing on rehabilitation rather than retribution. This may involve censuring past behaviour in order to change future behaviour, as well as ensuring proportionality in terms of sanctions and outcomes.[123] However, it has also been recognised that there are a number of potentially problematic factors which may need to be taken into account in designing an effective restorative justice process: namely, informality, power asymmetries, and the context in which the offence took place.

[121] Health and Disability Commissioner Act 1994, Public Act 1994, No 88 [reprint as at 24 March 2020]; see also Health and Disability Commissioner, www.hdc.org.nz/ (accessed 31 March 2020).
[122] R Paterson, 'Inquiries into Health Care: Learning or Lynching?' (2008) 121 J NZ Med Assoc 100; Ameratunga and others (n 72).
[123] Daly (n 96) 33; Miller and Blacker (n 96).

A more informal approach is recognised a hallmark of conferencing or meetings between the parties in restorative justice programs. On the one hand, informality may be conducive to open and frank discussions between victims, offenders and their supporters about how to right the wrongs that have been committed. On the other hand, it may prove problematic in terms of respecting the rights of the respective parties, as well as addressing the gravity of the harm that has been caused. This is in addition to ensuring that what is agreed is implemented to the satisfaction of all parties. Examples where informality may prove problematic include where offenders assume a dominant position, with a view to exerting power or undue influence over victims and their supporters.[124] In order to counter concerns about informality and the potential adverse consequences that may result, it would be important to make clear in what circumstances recourse would be needed to formal criminal justice processes for the purposes of judicial oversight.[125]

There would also be a need to consider the context in which a restorative approach is employed given the nature of the offence involved, and the relationship between the parties. For example, restorative justice programs have for the most part been used to address relatively minor crimes, in particular those involving young people,[126] or as part of transitional justice initiatives to address the legacy of past human rights' abuses or other criminal activity in post-conflict societies.[127] In contrast, seeking to employ such an approach in cases which involve family or sexual violence has

[124] Roche (n 103) 632.
[125] K McEvoy, H Mika and B Hudson, 'Introduction: Practice, Performance and Prospects for Restorative Justice' (2002) 42 British Journal of Criminology 470; J Braithwaite, 'Accountability and Responsibility through Restorative Justice' in M Dowdle (ed), *Rethinking Public Accountability* (CUP 2006) 33-51.
[126] See generally G Bazemore and L Walgrave (eds) *Restorative Juvenile Justice* (Criminal Justice Press 1999); M Suzuki and WR Wood, 'Is Restorative Justice Conferencing Appropriate for Youth Offenders?' (2018) 18(4) Criminology and Criminal Justice 450.
[127] K McEvoy and A Eriksson, 'Who Owns Justice? Community, State and the Northern Ireland Transition' in J Shapland (ed), *Justice, Community and Civil Society: A Contested Terrain (*Willan Publishing, 2008) 157-89.

been criticised as inappropriate, serving only to create further trauma for victims.[128] The question of what constitutes 'community' also requires careful consideration, as this may be viewed differentially by victims and offenders. Depending on a particular party's vantage point, this could inform how questions of redress and rehabilitation are interpreted, in addition to the degree to which there will be compliance with agreements reached between the parties.[129] In sum, account would need to be taken not only of the nature, type and context of the offence, but also the particular power, relationship and community dynamics that exist between parties involved in the restorative justice process.

In designing and implementing a restorative justice approach that could be employed in GNM cases involving healthcare professionals, it would be important that account be taken of these factors in ensuring that the of rights of all parties were protected, and that appropriate procedural safeguards were in place for the conduct of the process. This would include establishing the conditions and criteria for referral and review of cases; ensuring that informed consent had been obtained from victims regarding their participation; developing protocols to manage power asymmetries between parties; facilitating consultation with legal representatives both before and after legal proceedings; requiring facilitators involved in restorative justice meetings be appropriately qualified; and providing ongoing financial support to facilitate the participation of parties in such programs.[130] Taking account of such factors would also be consistent with

[128] See K Daly, 'Restorative Justice and Sexual Assault: An Archival Study of Court and Conference Cases' (2006) 46(2) British Journal of Criminology 334; AM McAlinden, *The Shaming of Sexual Offenders: Risk, Retribution and Reintegration* (Hart 2007) 5-10.
[129] A Eriksson, 'Restorative Justice in the Northern Ireland Transition' in AM McAlinden and C Dwyer (eds) *Criminal Justice in Transition: The Northern Ireland Context* (Hart 2015) 341-61; Vines (n 104) 370.
[130] United Nations, Basic Principles on the Use of Restorative Justice Programmes in Criminal Matters, Part III, para 11, ESC Res 2002/12, UN ESCOR, 37th plen mtg, UN Doc E/Res/2002/12 (24 July 2002). See also AM McAlinden and B Naylor, 'Reframing Public Inquiries as "Procedural Justice" for Victims of Institutional Child Abuse: Towards a Hybrid Model of Justice' (2016) 14 Syd L Rev 277.

recommendations made arising from previously implemented restorative justice programs in England.[131]

In terms of a way forward, we would suggest that a pilot programme be established to identify whether, and if so how, a restorative justice approach might work in practice in cases which give rise to GNM investigations/prosecutions involving healthcare professionals. In doing so, it would be important that the above-mentioned factors were included in the programme's design and implementation. As a starting point, it would require the consent of victims (deceased patients' families) and offenders (healthcare professionals), in addition to an assessment being undertaken regarding the suitability of referring individual cases to the programme. To facilitate a joined-up approach, oversight should be provided by a panel comprising representatives of professional regulators, prosecutorial authorities, the criminal justice system and the NHS, in addition to peer and lay members. The work of the panel would involve reviewing assessments and making decisions about what cases were suitable for referral; facilitating ongoing evaluation of relevant protocols and referral criteria; examining what options for redress should be made available to victims; and exploring what mix of regulatory techniques might work best in facilitating the pilot in these circumstances.

Given the mixed success of restorative justice schemes,[132] it would also be vital that evaluation mechanisms were put in place to assess the merits of using such an approach in cases of GNM

[131] Drawing on the findings from the implementation of restorative justice schemes in England, see D Miers and others, 'An Exploratory Evaluation of Restorative Justice Schemes' (Home Office 2001) x; C Hoyle and R Young, 'Restorative Justice: Assessing the Prospects and Pitfalls' in M McConville and G Wilson (eds) *The Handbook of the Criminal Justice Process* (OUP 2002) 525-48.

[132] ibid; see also J Shapland, G Robinson and A Sorsby, *Restorative Justice in Practice* (Routledge 2011); H Strang, 'Experiments in Restorative Justice' in P Drahos (ed) *Regulatory Theory: Foundations and Applications* (ANU Press 2017) 483-98.

involving healthcare professionals. In light of the seriousness of the offence, it would also ensure that learning from the pilot informed future policy options particularly given broader questions of public utility and legitimacy. As highlighted earlier in this paper, the number of these cases remains relatively low, so the implementation of such a pilot would not represent an onerous burden for key stakeholders in terms of investment in personnel, finances or administrative support. Given the government's overarching responsibility for the provision of healthcare through the NHS in England, it is also well positioned to take the initiative in this area, underpinned by institutional agreement and/or legislative remit.

IV. CONCLUSION

This paper examined the merits of employing a restorative justice approach as part of developing a just culture in addressing fatal errors by healthcare professionals within the NHS in England. Reviewing recent legal developments revealed an increasingly punitive approach to dealing with such errors, which now makes England an outlier when compared to other common law jurisdictions. This was exemplified in increased recourse to GNM investigations and prosecutions, although success in obtaining convictions remained elusive in the majority of cases. Where such convictions do take place, lengthier and more severe sanctions are now applied by both the courts and professional regulators. Although the reasons for these recent developments are complex, it is clear that there is now much less deference shown towards healthcare professionals, in addition to declining public trust in regulators given recurring episodes of poor healthcare practice in the NHS. In this regard, the use of the criminal law may be seen as symbolic of the need to show that such episodes undermine the social contract and are neither politically nor publicly acceptable. This is despite little evidence that it operates as a deterrent in the case of fatal errors on the part of healthcare professionals.

As highlighted in the recent *Bawa-Garba* litigation, systemic failures often play a contributing role in the substandard care by individual healthcare professionals that results in the death of patients. Although we do consider that there is a residual role for the criminal law in cases where a healthcare professional intentionally or recklessly causes either injury to, or the death of, patients, it is hard to see how the current lopsided prosecutorial approach, which focuses predominantly on fatal errors by individual healthcare professionals, can be justified. This is quite apart from the fact that as things stand, insufficient account is taken of the complex decision-making and often under-resourced environments in which they work. This is combined with the fact that systems learning and professional accountability mechanisms are put on hold, often for lengthy periods, as formal criminal processes proceed under the existing retributive model.

In the circumstances, we see merit in exploring whether a restorative justice model should be adopted in cases of GNM against healthcare professionals, which operates in a way that is complementary to the existing retributive model. The use of such an approach would be guided by the key principles of redress and rehabilitation and would help to foster an environment in which greater consideration could be given to the role played by systems failures in contributing to substandard care resulting in the death of patients. Employing such an approach also has the potential to promote healing and right wrongs in the context of not only the moral (and legal) obligations underpinning patient-doctor relations, but also the broader social contract within which the NHS operates. It is an approach which also offers greater scope to focus on the voice and needs of victims, such as bereaved families.

We further proposed that the merits of using a restorative approach in these cases should be assessed in the first instance through a pilot scheme. Such a scheme would need to provide a

structured pathway for using a restorative justice process which would include incorporating the use of protocols and safeguards for both victims and offenders, and a joined-up approach on the part of the government and key stakeholders to facilitate oversight and evaluation in the interests of transparency, accountability and policy learning. While this paper has focused on the use of a restorative justice approach in the specific case of fatal errors by healthcare professionals giving rise to GNM investigations/prosecutions under English law, it is an approach that could potentially be employed to address a broader range of harms suffered by patients and their families as a result of healthcare malpractice. Underpinned by a principled commitment to redress and rehabilitation as outlined in the paper, it is our view that it should be seen as a key component of building a just culture in patient safety within the NHS.