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A GROSS INJUSTICE: REEVALUATING THE BEHAVIOURAL STANDARD REQUIRED FOR GROSS NEGLIGENCE MANSLAUGHTER IN THE CONTEXT OF MEDICAL MISTAKES

Submitted for the LLB (Honours) Degree

Faculty of Law

Victoria University of Wellington

2018

Abstract

In the United Kingdom, where the law of manslaughter is similar to New Zealand, there have been two recent successful prosecutions of doctors for gross negligence manslaughter (GNM) in circumstances some would consider unfair. The convictions of doctors David Sellu and Hadiza Bawa-Garba have garnered significant public attention and provoked debate amongst legal and medical professionals as to the appropriateness of manslaughter prosecutions in the context of medical error. One concern is that these prosecutions failed to consider serious underlying concerns surrounding the tragic deaths of both patients, including hospital underfunding and systems errors. Equally, it is alleged that the prosecutions will have unintended and serious consequences for patient care and safety, including a decrease in error reporting and practitioners' self-reflection. The question, therefore, is how a similar prosecution could be avoided in New Zealand. This essay will analyse why the United Kingdom cases are problematic and how New Zealand law could be changed to address the correct level of culpable behaviour. Ultimately, it will propose that the correct behavioural standard required for a GNM conviction ought to be recklessness.

Key words: gross negligence manslaughter, doctors, recklessness, medical error

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I Introduction

In the United Kingdom, where the law of manslaughter is similar to New Zealand, there have been two recent successful prosecutions of doctors for gross negligence manslaughter (GNM) in circumstances some would consider unfair. The convictions of doctors David Sellu and Hadiza Bawa-Garba have garnered significant public attention and provoked debate amongst legal and medical professionals as to the appropriateness of manslaughter prosecutions in the context of medical error. One concern is that these prosecutions failed to consider serious underlying concerns surrounding the tragic deaths of both patients, including hospital underfunding and systems errors. Equally, it is alleged that the prosecutions will have unintended and serious consequences for patient care and safety, including a decrease in error reporting and practitioners' self-reflection.

The question, therefore, is whether a similar prosecution could occur under New Zealand law. While in New Zealand, prosecutions for manslaughter against medical professionals are rare, with no prosecutions since 2006, that could easily change.[1] For the purposes of clarity and brevity, this essay will address the regulation and conduct of 'doctors' as a subset of the wider medical profession. The two prosecutions in the United Kingdom were of doctors specifically.[2] Therefore, the issues they illuminate, while also relevant to the applicability of GNM to medical practice more generally, are of greatest concern when examining the conduct of doctors. This essay will analyse why the United Kingdom cases are problematic and how New Zealand law could be changed to achieve a fairer scheme that addresses the correct level of culpable behaviour. Ultimately, it will propose that the correct behavioural standard required for a GNM conviction ought to be recklessness.

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[1] Warren Brookbanks "Medical manslaughter: Criminalisation or Restoration" (Professorial Lecture, Auckland University of Technology, Auckland, 14 March 2017).

[2] While two nurses were also accused of GNM and one was later convicted over the death of Jack Adcock.

Part II of this essay will examine the background to the law of GNM in New Zealand and the United Kingdom, as well as the regulatory framework in place in New Zealand to regulate doctors.

Part III will outline the two United Kingdom cases and identify the reasons the prosecutions are problematic.

Part IV will consider what level of moral culpability the law of GNM ought to be requiring in the medical context. This will be achieved through comparing the conduct of the two United Kingdom doctors to a case where the doctor's actions were arguably more morally culpable but escaped conviction for GNM.

Part V will discuss the question of what to do about the problems illuminated by the case studies.

Part VI will propose a solution to be adopted in New Zealand to avoid the same problems from the United Kingdom experience occurring here.

II Background

A *The Law of GNM*

The relevant provisions of the Crimes Act 1961 are ss 150A–157. Alleged negligent doctors are most frequently prosecuted under s 155.[3] Before 1997 the behavioural standard necessary for a GNM conviction under the s 150 offences required only proof of ordinary and not gross negligence.[4] Following a string of prosecutions of medical professionals for manslaughter in the 1990s, the most famous of which being *R v*

[3] Ron Paterson "From prosecution to rehabilitation: New Zealand's response to health practitioner negligence" in Amel Alghrani and Danielle Griffiths (eds) *Bioethics, Medicine and the Criminal Law. Volume 2: Medicine, Crime and Society* (Cambridge University Press, Cambridge, 2013) 229 at 231.

[4] Margaret Brazier "The Criminal Process and Medical Practitioners: Shield and Sword" in Mark Henaghan and Jesse Wall (eds) *Law, Ethics and Medicine: Essays in Honour of Peter Skegg* (Thomson Reuters New Zealand, Wellington, 2016) 7 at 8.

Yogasakaran,[5] a strong and well-resourced campaign was championed by the New Zealand Medical Law Reform Group. This group was particularly concerned that those in high-risk specialties, such as cardiothoracic surgery or anaesthesia, would be particularly vulnerable to prosecution, one of the obvious requirements for a manslaughter prosecution being the death of a patient.[6] The campaign in part led to the McMullin report, which argued that a change should be made to the behavioural standard required for a conviction under the s 150 offences to require 'a major departure from the standard of care expected of a reasonable person to whom that legal duty applies in those circumstances'.[7] This requirement was inserted via the new section 150A in 1997.[8] The new wording had the effect of changing the necessary standard from ordinary to gross negligence.[9] Ostensibly, the law change removed the threat of a health practitioner facing a manslaughter prosecution in the absence of other circumstances indicating a severe lack of care.[10]

In the United Kingdom, the standard for manslaughter in this context is also gross negligence. There is no equivalent statutory regime to New Zealand's ss 150A–157, but the case law of gross negligence manslaughter is applied where a person causes death through extreme carelessness or incompetence.[11] The classic test for gross negligence manslaughter in the United Kingdom comes from the House of Lords in *R v Adomako*[12] and this test has been applied in New Zealand.[13] It requires the proof of four elements: that the defendant owed the victim a duty of care; that the defendant was in breach of that duty; the breach caused the victim's death; and that breach of duty should be

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[5] [1990] 1 NZLR 399 (CA), in Alexander McCall Smith "Criminal or Merely Human? The Prosecution of Negligent Doctors" (1995) 12 J.Contemp.Health L.& Pol'y 131 at 143.

[6] Alan Merry "Mistakes, Misguided Moments, and Manslaughter" (2000) 41 J Extra Corpor Technol 2 at 3.

[7] *Report of Sir Duncan McMullin to Hon Douglas Graham, Minister of Justice, on Sections 155 and 156 of the Crimes Act 1961* (Ministry of Justice, 1995) at 50.

[8] Crimes Amendment Act 1997, s 2.

[9] *R v McKie* HC Dunedin T13/00, 31 July 2000 at [30].

[10] Paterson, above n 3, at 232.

[11] Law Commission (UK) *Legislating the Criminal Code: Involuntary Manslaughter* (Law Com 237, 1996) at [2.8].

[12] [1994] 3 All ER 79 (HL).

[13] *R v McKie*, above n 9.

characterised as gross negligence. The question of 'grossness' depends on the seriousness of the defendant's breach of duty and is to be assessed in all the circumstances in which the defendant was when the breach occurred. In this way, the law of GNM is merely an application of the ordinary principles of the law of negligence.[14]

The role of a jury in a GNM prosecution is, crucially, to decide whether the conduct of the accused constituted a major departure from the standard of care expected of a reasonably experienced person in the circumstances (for the purposes of this essay, a reasonable doctor). While medical experts give evidence as to the quality of the accused's decision-making, this evidence is not determinative, and it is ultimately for the jury to evaluate this question. The definition of GNM has been criticised for its circularity, with juries in practice being effectively directed to convict of a crime if they believe a crime has been committed.[15]

B *The Regulatory Framework for Doctors*

A useful summary of the structure of the statutory regime is provided by Adam Holloway.[16] The regulatory framework for doctors operates as the main avenue for addressing doctors' misconduct and operates independently of the criminal law, which is reserved for behaviour at the most serious end of the spectrum of misconduct. The criminal law will intervene in a very limited number of circumstances. The starting point when addressing the regulation of doctors is the Health Practitioners Competence Assurance Act 2013 (the HPCA Act). The principal purpose of the Act is "to protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practise their professions".[17] This highlights the overarching theme of patient safety woven into the legislative framework. The Medical Council of New Zealand (MCNZ) is the foremost regulatory body responsible

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[14] *R v Adomako*, above n 12, at 187.

[15] Margaret Brazier and Neil Allen, 'Criminalising Medical Malpractice' in Charles A Erin and Suzanne Ost (eds) *The Criminal Justice System and Health Care* (Oxford University Press, Oxford, 2007) 15 at 21.

[16] Adam Holloway "Fit For Purpose? An Examination of the Jurisdiction of the Health and Disability Commissioner in New Zealand" (LAWS 513 Research Paper, Victoria University of Wellington, 2013).

[17] HPCA Act 2013, s 3(1).

for doctors.[18] The MCNZ assesses doctors' fitness to practise, as well as issuing annual practising certificates.[19] The HPCA Act includes methods of reviewing doctors' competence, allowing MCNZ to impose conditions on the scope of a doctor's practice as well as any additional requirements such as retraining. In limited circumstances, the MCNZ is entitled to order the interim suspension of a doctor.[20]

The HPCA Act also establishes the Health Practitioners Disciplinary Tribunal (HPDT), which hears charges of professional misconduct. The grounds on which a doctor may be disciplined by the HPDT are outlined in s 100 and include matters such as professional misconduct that amounts to malpractice or conduct that might bring the profession into disrepute.[21] If the HPDT finds against a doctor under one or more grounds in s 100, various penalties may be applied, including cancellation of registration.[22]

Broadly, the Health and Disability Commissioner's role is central, as every complaint about a doctor must be first referred to the Commissioner. The MCNZ may, in certain circumstances, take interim steps against a doctor as outlined above to protect the public, but nothing else, while the complaint is being dealt with by the Commissioner. Following an investigation which concludes that a doctor has breached the Code, a charge may be laid either a) by the complainant before the Human Rights Review Tribunal; or b) by the Director of Proceedings before the Human Rights Review Tribunal (alleging a breach of the Code) or the HPDT (alleging a breach of the HPCA Act). Where the Commissioner is no longer involved, the MCNZ may refer the matter to a professional conduct committee, which may, among other things, bring a charge against the doctor before the HPDT.[23] This illustrates that there are numerous accountability mechanisms to address doctors' misconduct that do not invoke the criminal law.

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[18] HPCA Act, ss 11–14.

[19] Sections 13–33.

[20] Sections 34–51.

[21] Section 100.

[22] Section 101.

[23] Holloway, above n 16, at 3.

III The United Kingdom Cases

A *Dr David Sellu*

James Hughes was 66 when he underwent elective total knee replacement surgery in 2010 and initially appeared to be quite healthy for his age.[24] Some days after the operation, Hughes complained of abdominal pain. Following what were alleged by the prosecution to be a series of grave errors in judgement by the defendant Dr Sellu, a colorectal surgeon, Sellu performed an emergency operation, but Hughes died a day later. Sellu was a senior consultant with an impeccable record – he was the first choice for emergent abdominal problems, and experts agreed at trial that prior to this incident Sellu had a reputation as a faultless surgeon who exercised a high degree of care.[25] Sellu was charged with GNM, the Crown alleging a failure in urgency to treat Hughes' deteriorating condition substantially contributed to the death. He was convicted by a 10:2 majority jury verdict and sentenced to two-and-a-half years' imprisonment. The imprisonment was an especially surprising element of this case, as very few prosecutions of doctors result in a custodial sentence.[26]

Experts called by the prosecution at trial alleged a number of serious deficiencies in Sellu's care of Hughes. One expert described Sellu's actions as "a bizarrely slow, laidback, and inadequate treatment and diagnosis regime which, if proposed by a candidate for a basic doctors' exam would have resulted in a fail".[27] Conversely, both Sellu and an expert for the defence argued Hughes' condition did not indicate someone in need of urgent care, and that the patient had died because he had not been able to "withstand the septic insult" he experienced as the emergency surgery began.[28] Overall, the defence expert concluded the treatment plan had been reasonable.

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[24] *R v Sellu* [2016] EWCA Crim 1716, [2017] 4 WLR 64 at [2].

[25] *R v Sellu*, above n 25, at [25].

[26] Peter Skegg "Criminal Prosecutions of Negligent Health Professionals: The New Zealand Experience" (1998) 6 Med L Rev 220 at 239.

[27] *R v Sellu*, above n 25, at [46].

[28] At [75].

The case for the defence (and that was subsequently advanced in the media by Sellu's supporters) was that there had been serious systems failures that contributed to the death that were not attributable to Sellu. These were that there was no emergency anaesthetist available on call, there was no theatre available for the procedure unless Sellu cut into elective surgery lists, and no one else at the time, including other doctors and nurses, had recognised the urgency of the situation.[29] Equally, it was noted by consultant surgeons following Sellu's conviction that many colorectal specialists frequently found themselves dealing with a similar patient presentation. One author noted that delay in such cases is not abnormal, and indeed 60 per cent of NHS patients needing urgent laparotomy did not reach theatre in the optimum time.[30]

Sellu appealed against his conviction and sentence, and the Court of Appeal in 2017 found that the judge's direction to the jury had been inadequate. In the Court's view, the direction did not sufficiently outline that the matter of whether the negligence was 'gross' was a matter for the jury and not the experts. For this reason, the conviction was unsafe and was quashed, the Crown Prosecution Service deciding not to seek a retrial.[31] By this time, however, Sellu had served fifteen months of his two-and-a-half-year sentence.[32] Leveson P appeared to have had real difficulty with the prosecution experts at trial repeatedly using the words 'gross negligence' to describe Sellu's conduct, as it was for the jury and not for the experts to determine the question of grossness, a principle established in *Adomako*.[33] Leveson P noted the judges were reinforced in their view that trial judge Nicol J's directions were insufficient by the jury's question of whether they were "deliberating legalities or … judging as human beings, lay people".[34] Nicol J had

[29] Peter McDonald and Jenny Vaughan "The aftermath of Sellu for the law and medical professions" (2018) 100 The Bulletin of the Royal College of Surgeons of England 207 at 208. It should be noted that both authors were members of the Friends of David Sellu campaign.

[30] Peter McDonald "Medical manslaughter and the case of David Sellu" 99 The Bulletin of the Royal College of Surgeons of England 104 at 104.

[31] Clare Dyer "Senior surgeon's conviction for manslaughter is quashed" (16 November 2016) 355 BMJ.

[32] Peter McDonald "The expert medical witness: the good, the bad and the ugly" (2017) 8(2) Trends in Urology & Men's Health 29 at 29.

[33] Peter McDonald, above n 32, at 105.

[34] *R v Sellu* [2017], above n 25, at [154].

repeated his initial directions but failed to identify where the line should be drawn between expert and layperson.[35]

The saga was essentially brought to a close with the Medical Practitioners Tribunal Service's 6 March 2018 announcement that the interim practice order placed by the General Medical Council (GMC) on Sellu was immediately revoked.[36] The *Sellu* case did change GNM law in that jury directions in must be more tightly controlled to ensure the jury is properly informed of its role in a GNM case, but serious questions still remain as to how he was convicted in the first place.

B *Dr Hadiza Bawa-Garba*

Jack Adcock was six years old and was diagnosed from birth with Down Syndrome. This caused a congenital heart condition, for which he was receiving medication, enalapril. Adcock was admitted to hospital after being unwell through the night and the day before, presenting with dehydration caused by vomiting and diarrhoea, with shallow breathing and his lips slightly blue. By the time he reached hospital he was unresponsive and limp. He was seen by a nurse who immediately asked that he be assessed by the most senior junior doctor on duty at that time, Dr Bawa-Garba. Bawa-Garba, the Court accepted, was a registrar with an excellent history and no previous incidents to her name. Bawa-Garba had recently returned from fourteen months' maternity leave and was in sole charge of the emergency department and Children's Assessment Unit that day as there was no senior consultant available. She had worked a double shift that day (twelve to thirteen hours straight) without any breaks, and faced significant clinical obstacles including, among others, a shortage of permanent nurses resulting in the use of temporary nurses and a failure in the hospital's electronic computer system, meaning Bawa-Garba received blood test results late and was without the assistance of a senior house officer as a result.

Adcock was initially treated for acute gastroenteritis (a stomach bug) and dehydration. Following an x-ray, he was treated for pneumonia with antibiotics. In fact, when Adcock

[35] Clare Dyer "Where should the buck stop?" (23 November 2016) 355 BMJ.

[36] McDonald and Vaughan, above n 29, at 207.

was admitted to hospital he was suffering from pneumonia which caused his body to go into septic shock, causing organ failure and at 7.45pm his heart to stop. Despite efforts to resuscitate him, Adcock died at 9.20pm. Expert evidence presented clinical signs of septic shock which were present in Adcock. The case for the Crown was that Bawa-Garba, along with two nurses also accused at trial of GNM,[37] contributed to, or caused Adcock's death, by serious neglect which fell so far below the standard of care expected of competent professionals that it amounted to the criminal offence of GNM. One of the errors that led to Adcock's death was the administering of enalapril by Adcock's mother, and it was alleged that Bawa-Garba had failed to note on Adcock's chart that the enalapril should be discontinued.

The issue in the case concerned causation – whether Bawa-Garba's actions caused or at least significantly contributed to Adcock's death.[38] As required, the trial judge left it to the jury to decide this question. The jury ultimately convicted Bawa-Garba of GNM and she was sentenced to a two-year suspended prison term. It is interesting to note the marked difference in sentence between an immediate custodial sentence in *Sellu* to a suspended sentence here, which is in line with the sentencing pattern of most GNM cases of this nature.[39] Bawa-Garba was subsequently suspended from practising medicine for twelve months by the Medical Practitioners Tribunal, the Tribunal rejecting erasure from the register as disproportionate.[40] The GMC took the unusual step of appealing the Tribunal's decision to the High Court, arguing for Bawa-Garba's erasure. The GMC's contention was that erasure was the only punishment appropriate in the circumstances to maintain public confidence in the profession. The appeal was allowed and Bawa-Garba's name was struck from the register, meaning she could never again practice medicine in the United Kingdom.[41] The High Court held that the Tribunal had gone beyond the jury's verdict and ruled, despite the jury finding her errors on that day were 'truly exceptionally

[37] Nurse Isabel Amaro was also convicted at trial of GNM, another nurse was found not guilty.

[38] *Bawa-Garba v R* [2016] EWCA Crim 1841 at [19].

[39] Skegg, above n 26, at 239.

[40] *GMC v Bawa-Garba* [2018] EWHC 76 (Admin) at [5].

[41] At [54]. Bawa-Garba successfully appealed her erasure in *Bawa-Garba v GMC* [2018] EWCA Civ 1879. Her conviction for manslaughter still stands.

bad', that Bawa-Garba's fitness to practise was not impaired to such an extent as to justify erasure. In the High Court's view, the Tribunal's decision was fundamentally incorrect.[42]

Bawa-Garba's conviction and erasure caused widespread, public outcry from many corners of the medical sector. Special criticism was levelled at the alleged use of Bawa-Garba's personal reflections in the case. Doctors training in the NHS must keep reflections on their training. It was suggested by a number of doctors that her reflections were used by the prosecution to help their case, although her counsel in her most recent appeal denied this was so.[43] In an open letter, doctors raised grave concerns that this would discourage doctors from open self-reflection in the future, rolling back years of progress.[44] The public attention in both the mainstream press and medical and legal publications prompted Health Secretary Jeremy Hunt to announce a review into how GNM is applied in the United Kingdom in the medical context.[45] However, there are concerns that the review is too narrow and does not adequately address concerns about the use of the criminal law to punish individuals whose conduct falls short of recklessness or advertent carelessness.[46] Needless to say, there is significant consternation among the medical community around the Bawa-Garba case and its wider implications for the health sector. The next question is why that is.

C *What Is Problematic About These Cases?*

The above cases concern individuals whose conduct does not on its face suggest sufficient blameworthiness so as to attach to it a manslaughter conviction. Neither doctor was shown to have exhibited conscious disregard for the risks involved in their treatment of their patients. Rather, their conduct was deemed by the jury to have been a major departure from the standard required of a competent doctor in the circumstances. Plainly,

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[42] *GMC v Bawa-Garba*, above n 40, at [53].

[43] David Nicholl "The role of reflection in the post Bawa-Garba era" (29 June 2018) Royal College of Physicians <www.rcplondon.ac.uk>.

[44] Nicholl, above n 43.

[45] Gareth Iacobucci "Health secretary orders review into use of medical manslaughter" (6 February 2018) 360 BMJ.

[46] Toby Reynolds "Narrow terms of reference mean that Jeremy Hunt's review of gross negligence manslaughter will miss the point" (20 April 2018) 361 BMJ.

then, if their conduct does not on its face merit conviction for manslaughter, it would appear the law is not achieving its proper object. The discussion around the appropriateness of prosecuting doctors for conduct short of recklessness or extreme carelessness takes place as part of the general debate around criminalising any form of negligent conduct, that is, conduct absent the normal mens rea.[47] However, in the medical context there is a salient issue: error. Medical practitioners are in fact human beings carrying out activities carrying widely varied degrees of risk in relation to patient safety. As with all humans, medical practitioners are inherently prone to some level of error. A discussion of error is important to understanding the inappropriateness of the two GNM prosecutions above.

The current method of defining an objective behavioural competence standard does not adequately account for the human propensity for error. A reasonable person at the time is one who is not, for example, tired, nor distracted. [48] A failure to meet this standard does not necessarily mean the actor is morally culpable and indeed, while the statistical inevitability of errors does not excuse any particular error, it does reinforce the suggestion that such errors are less likely to be the result of culpable neglect.[49] Doctors are required to be highly skilled and make well-reasoned judgements on a daily basis.[50] While most doctors are competent most of the time, there is empirical evidence to suggest that most doctors make potentially serious errors from time to time.[51] This evidence does not support a conclusion that the vast majority of doctors are negligent, but what it does show is that each doctor is fallible and will, on occasion, fall below the required standard of care as currently formulated.[52]

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[47] McCall Smith, above n 5, at 131.

[48] Alan Merry and Warren Brookbanks *Merry and McCall Smith's Errors, Medicine and the Law* (2nd ed, Oxford University Press, Oxford, 2017) at 228.

[49] McCall Smith, above n 5, at 135.

[50] At 135.

[51] Alan Merry and Donald Peck "Anaesthetists, errors in drug administration and the law" (1995) 108 NZ Med J 185. This survey of anaesthetists revealed that 89 per cent of the participants made potentially serious errors in their practice.

[52] McCall Smith, above n 5, at 135.

Scholars in this area have distinguished undesirable outcomes as the result of either errors or violations.[53] The former involve 'slips' in behaviour and are made by experts and novices alike.[54] The latter, however, involve choice, so in legal terms it may be possible to deter them. It is almost inevitable that a doctor carrying out high-risk, difficult procedures on a regular basis will make an error, and it is difficult to argue that it should be the role of the criminal law to punish human errors that are not morally culpable.[55] Furthermore, doctors have less choice than most in relation to risk-taking:[56]

> A surgeon cannot usually refuse to operate; risk (even risk of death) is an inherent part of medicine. Judgements have to be made instantly. The risk averse doctor may do more harm than good.

Merry poses that to ask whether an error is reasonable in the context of an objective behavioural standard is to misunderstand the nature of error – there is nothing reasonable about error per se.[57] It is well known and has been empirically suggested that anaesthetists regularly administer the wrong drug,[58] and while this is clearly not a reasonable thing *to do*, it is clearly something done by reasonable *doctors*. In this way, Merry's proposed analysis focuses not on the act, but on the person doing the act.[59] Lord Denning proposed a question to be asked of the average competent and careful practitioner in the GNM context as:[60]

> 'Is this the sort of mistake that you yourself might have made?' If he says 'Yes, even doing the best I could, it might have happened to me', then it is not negligent.

It has been suggested that what Lord Denning meant here was that an error was not necessarily negligent, not that *no* errors are negligent – it will depend on the nature of the

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[53] Merry, above n 6, at 2.

[54] Merry, above n 6, at 2.

[55] Alexander McCall Smith and Alan Merry "Medical Manslaughter: A Reply to Paterson" (1996) 4 Health Care Analysis 229 at 229.

[56] Brazier and Allen, above n 15, at 21.

[57] Merry, above n 6, at 2.

[58] Merry and Peck, above n 51.

[59] Merry, above n 6, at 4.

[60] *Whitehouse v Jordan* [1980] 1 All ER 650 (CA) at 658.

error.[61] Certainly, however, it has been judicially acknowledged to a limited extent that certain errors are clinically inevitable, and that punishing all errors as negligent is an arbitrary approach which does not examine the person doing the act.

An interesting view on the topic of errors criticises the current focus on the outcome rather than the process by which the error(s) were made. Merry argues that if two doctors make exactly the same error and by pure chance only one of the patients dies, the doctor whose patient died would be treated far differently to the doctor whose patient survived, despite the conduct leading to both outcomes being identical.[62] Merry poses that focusing on the harm caused is not a sound method of assessing blameworthiness.[63] Indeed, his article notes, serious harm may follow innocent actions. For instance, administering a drug to a patient with an unknown allergy may cause a fatal anaphylactic reaction. Equally, conduct that is intended to harm, whether it succeeds in causing such harm or not, ought to be punished.[64] The law as currently formulated does not achieve this. One rather extreme formulation of this school of thought states:[65]

> if Sellu could be sent to jail then the whole medical profession should be incarcerated with him – for the precise diagnosis of severe illness is such an imperfect science that we have all at times fallen foul of it and made similar errors.

A serious concern in both of the Sellu and Bawa-Garba cases was that in each case serious hospital systems failures occurred that contributed to the decisions made by the doctors and impacted the patients' treatment. By prosecuting for GNM, there was no room made for a focus on the impact of outside factors on each doctor's decision-making.[66] Supporters of Sellu, in a letter to the President of the Royal College of Surgeons, asserted that prosecution of (and jailing of in Sellu's case) doctors for GNM

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[61] *Whitehouse v Jordan* [1981] All ER 267 (HL) at 280–281 per Lord Fraser.

[62] Merry, above n 6, at 2.

[63] At 4.

[64] At 4.

[65] McDonald and Vaughan, above n 29, at 208.

[66] Sarah Boseley "Doctors sign letter expressing worry over criminalization of surgeon" *The Guardian* (online ed, London, 6 August 2015).

has the real possibility of allowing systems failures to recur, placing more patients at risk of death.[67] The letter was signed by 313 medical staff. The assertion, broadly, is that the more the criminal law is involved, the less likely people are to learn lessons from tragic deaths and the system is to improve.[68] It is crucial that the focus in an unexpected death inquiry is not only on the individual doctor but on the system they were working in.[69]

Similarly, more than 10,000 doctors signed a letter responding to the High Court's ruling that Bawa-Garba's name should be erased from the register.[70] The letter drew particular attention to both the alleged use of Bawa-Garba's personal reflections in the prosecution and the concern among all NHS doctors that they had worked in similar conditions as Bawa-Garba experienced that day.[71] A frequent comparison made in the medical context is to another risk-heavy industry: the airline industry. The letter noted that a pilot would not, and would not be required to, take off if the captain and most of the crew were not on the plane.[72] Doctors, on the other hand, do not have this option, and frequently take on the work of one or more other doctors in order to keep hospitals running. Bawa-Garba was in sole charge of the paediatric unit the day Adcock died, and was covering the work of at least one other doctor.[73]

The sentences handed down following GNM convictions tend to be more lenient than other manslaughter sentences. Sellu's incarceration aside, Bawa-Garba's suspended sentence is in line with GNM sentencing in both jurisdictions.[74] It is common in New Zealand following a manslaughter conviction of a doctor for the doctor to receive a

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[67] Boseley, above n 71.

[68] Boseley, above n 71.

[69] The Royal College of Surgeons acknowledged this in Boseley, above n 71.

[70] Nick Bostock "More than 5,000 GPs sign Bawa-Garba protest letter" (29 January 2018) GP Online <www.gponline.com>.

[71] Bostock, above n 72.

[72] Phil Whitaker "Dr Hadiza Bawa-Garba was left in charge of a failing aircraft – and there are many others like her" *New Statesman* (London, 15 February 2018) 57 at 57.

[73] At 57.

[74] Skegg, above n 26, at 239; and Hannah Quirk "Sentencing white coat crime: the need for guidance in medical manslaughter cases" [2013] Crim Law Rev 871 at 872.

suspended sentence, a fine, or indeed no sentence at all.[75] A conviction for manslaughter has been acknowledged to have a significant detrimental effect in and of itself on a doctor's career.[76] However, if the sanction imposed by the criminal system is so lenient, it lends weight to criticism that this is not the proper scope of the criminal law. It may be that these lenient sentences reflect judicial reluctance to impose a heavy sanction for conduct which is not highly morally blameworthy. If this is the case, it indicates the unsuitability of the current GNM scheme to address medical mistakes. This becomes especially clear when comparing the conduct of Sellu and Bawa-Garba to another high-profile case of 'medical manslaughter' and the comparative blame that ought to be attached to each. The next section will examine this high-profile case.

IV Ramstead: More Morally Blameworthy?

Keith Ramstead was a cardiothoracic surgeon based in Christchurch. His performance during his short tenure in 1991–1992 led to an inquiry and report by the Royal Australasian College of Surgeons which examined five cases in which patients had died during surgery and two others where the patients had died following surgery. The report identified serious deficiencies in Ramstead's work and concluded that the seven cases had been managed incompetently.[77] These seven cases were then investigated by the police, along with two others that had been referred to them by the coroner. Ramstead was charged with the manslaughter of three patients, all involving patients who died in the operating theatre during or immediately after operations for cancer or suspected cancer.[78] Following a five-week trial, a jury found Ramstead guilty of the manslaughter of one patient, Nancie Muncie, but not guilty of the other two deaths. In respect of Muncie's death, it was alleged that during a lung removal he put a clamp in the wrong place, thereby impeding the flow of blood to both lungs rather than simply blocking the flow to the lung that he was removing. The jury indicated to the judge that "in all three cases due care, skill and knowledge were breached but we were unable to establish these failures as

[75] Skegg, above n 26, at 239.
[76] *Long v R* [1995] 2 NZLR 691 (HC) at 700.
[77] Skegg, above n 26, at 232.
[78] At 232.

an essential cause", so the two acquittals would appear to have resulted from a failure to prove causation.[79] Ramstead was sentenced to six months' imprisonment, suspended for six months.[80] He was subsequently struck from the medical register.

The fact that Ramstead caused sufficient concern in his short time practising in Christchurch to justify a regulatory body's inquiry invites comparison to the unblemished records of both Sellu and Bawa-Garba. Neither doctor had any infraction on their record and both were in fact regarded as above average and very competent prior to the deaths of both patients. Ramstead was convicted of one count of manslaughter amongst a group of patients that died in unexplained circumstances, where Sellu and Bawa-Garba's prosecutions were both for the death of a single patient in isolation. But for the procedural issue of the note to the judge, explained at 79 below, Ramstead would have been convicted for manslaughter and treated in the same way as (and sentenced more leniently than) both Sellu and Bawa-Garba.

Ron Paterson, former Health and Disability Commissioner, highlights several issues with the conduct that is potentially deemed culpable and worthy of prosecution for GNM under the law as it stands.[81] He states that during his tenure as Commissioner he reviewed files of practitioners who were guilty of major shortcomings in their care yet escaped prosecution. This is due to an inconsistency in dealing with cases of medical gross negligence. Some cases may be dealt with in the workplace by District Health Boards or professional regulatory bodies such as the Royal Australasian College of Surgeons, a few lead to an HDC investigation and the censure of a breach finding, while others lead to a competence review and, occasionally, the imposition of conditions on their practice. A coroner may hold an inquest and make recommendations for change. Only rarely would a practitioner be prosecuted for GNM.[82]

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[79] Ramstead's conviction was overturned by the Judicial Committee of the Privy Council for procedural impropriety regarding a jury note in *Ramstead v R* [1999] 1 NZLR 513 (PC). No retrial was ordered.

[80] *R v Ramstead* [1997] BCL 604 (CA) at 1.

[81] Paterson, above n 3, at 244.

[82] At 244.

Another of Paterson's concerns about invoking the criminal law for health practitioners other than in extraordinary cases is that it frustrates the normal channels of accountability that exist in the regulatory scheme. Paterson argues it is impractical for such agencies to independently investigate while a practitioner is facing a manslaughter charge, and consequently files are usually put on hold. When the lengthy criminal process is over, even if it results in an acquittal, it is very difficult for a regulatory body to 'turn the clock back' and commence its own investigation.[83]

A third concern, and one echoed by several prominent writers on the 'medical' side of the discussion, is that manslaughter prosecutions, even if calibrated at the major departure standard, risk driving mistakes underground by discouraging reporting of errors. While this may appear an overblown fear, isolated examples of a deterioration in reporting point to this being a real possibility. An Anaesthetic Mortality Assessment Committee was established by the Minister of Health in 1979, with its function being to receive and consider information relating to deaths which may have been related to anaesthesia and to promote the safe use of anaesthesia.[84] Practitioners who had administered anaesthetics which they thought may have been related to the deaths of patients were under a statutory duty to report the deaths and to provide other relevant information. The committee's function was not to attach blame but to determine the extent to which anaesthesia had contributed to the death and determine if the death might have been averted.[85] The ultimate aim was to reduce the incidence of avoidable deaths from anaesthesia. Information obtained in the course of the exercise of the Committee's powers was to be treated as confidential except for the purposes of the investigation of crime or any criminal proceedings, in order to encourage frank disclosure.[86] During its first decade, the Committee considered some 600 anaesthetic deaths which were reported to it. However, there was a marked decline in reporting of errors following police investigation of anaesthetic deaths in the 1980s, including the use of confidential disclosure as part of the

[83] Paterson, above n 3, at 244.
[84] Skegg, above n 26, at 242.
[85] At 242–243.
[86] At 243.

investigations.[87] Cooperation with the Committee sunk to such lows that by the end of 1993 the first chairman of the Committee reported that the Committee was "effectively defunct because of civil disobedience by those who campaigned for its establishment, namely the anaesthetists of New Zealand".[88] The steep decline in disclosure was attributed to a fear of prosecution by anaesthetists, and is empirical evidence to support the view that health practitioners are unlikely to share their mistakes in a peer review setting if a police search and prosecution is possible.[89] The overarching concern with the intervention of the criminal law is that the real causes of patient deaths will remain hidden, and the potential to learn from mistakes and remedy any failings in the system will be lost. While this Committee's demise occurred before the 1997 law change, the concerns about error reporting are still evident where doctors like Sellu and Bawa-Garba are still able to be captured under GNM.

A doctor's repeated clinical mismanagement, determined by a report of a professional body, culminating in several patient deaths, is on its face more morally blameworthy than a doctor having a 'bad day' and the death of a patient resulting from admitted clinical errors, as distinct from violations, combined with serious systems failures. Yet all three instances are treated the same and are equally captured under the law of GNM. This comparison in effect establishes a continuum of behaviour by doctors. On one end is repeated clinical incompetence, represented by Ramstead, and on the other is medical error compounded by external factors, represented by Sellu and Bawa-Garba. The level of behaviour manslaughter should be truly addressing ought to be firmly at the Ramstead end of the continuum and above.

V What Ought To Be Done?

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[87] Paterson, above n 3, at 244; and Skegg, above n 26, at 243.

[88] John Gibbs "A Review of the Attitudes of Anaesthetists to Medical Manslaughter and its Consequences for the Specialty: Speech of The First Chairperson of The Anaesthetic Mortality Assessment Committee" (Transcript of lecture given 19 November 1993) at 2 in Skegg, above n 26, at 243.

[89] Paterson, above n 3, at 244.

Clearly there is unrest in the medical community and beyond about these kinds of cases being caught by the law as it is currently formulated. This concern reflects an anxiety that doctors will be prosecuted for conduct that is not morally culpable and is in fact inherent in medical practice, in particular risky specialties. There must be a better way to balance the competing objectives of punishing culpable behaviour and ensuring patients are safe and receive the best quality treatment possible.

A *Clarification and Guidance for the Existing Standard?*

One approach to raising the standard is to keep the manslaughter standard at gross negligence but redefine the scope of its application. This would mean that it would be more likely that the Ramstead-type behaviour would be captured by ss 150A–157. The redefined approach would be designed to allow more consideration of the contributory errors of others and system failures to more adequately assess the conduct of practitioners. Given that in both cases of Sellu and Bawa-Garba there were serious concerns around the failure of systems during their treatment of patients, it would be essential to provide sufficient guidance in New Zealand as to the consideration of such systems errors to avoid the same kind of prosecution occurring here. This option is undoubtedly a 'gentler' reform approach and does not involve fundamentally altering the standard at which manslaughter will be assessed.

The guidance could come in the form of inserting a new s 150B into the Crimes Act. Titled "Factors to be taken into account in medical context" or similar, this section would provide a non-exhaustive list of certain factors that the court must consider when assessing culpability for GNM. These might include systems errors, the statistical likelihood of negative outcomes and staff or roster issues. This is not the ideal mechanism for clarifying the law for the following reasons.

It is arguably inappropriate to use GNM at all, even if redefined, for any error or departure from the standard of care short of reckless acts or omissions. The maintenance of the gross negligence standard in New Zealand would still leave the door open to a doctor being caught under the legislation for the commission of one or several errors that

did not amount to recklessness. This would be even more concerning if there were also systems errors at fault, something which various analyses of prosecutions for GNM have found are present to some extent in most cases brought to trial.[90]

Moreover, the concerns that have been raised about doctors increasingly becoming risk-averse would still be pertinent to this formulation of the law of manslaughter. The practise of 'defensive medicine' in this way has been defined as either positive or negative. [91] Positive defensive medicine involves providing services of nil or negligible medical value either to reduce adverse outcomes or to persuade the legal system that the standard of care was met, such as ordering tests and prescribing unnecessary drugs. This practice costs the health system more for no real benefit to patient safety, and the risks of unnecessary treatment may actually outweigh any potential benefit to the patient. Negative medicine, on the other hand, reflects doctors' attempts to distance themselves from sources of legal risk, either by forgoing high-risk procedures or refusing to treat high-risk patients. We want doctors to take reasonable risks and perform procedures that may involve high risk in order to improve a patient's quality of life. The concern that defensive medicine will creep into medical practice as the threat of prosecution looms is one that would remain under this formulation.

The question of "why are doctors different?" will inevitably arise. It is true that any different treatment of doctors must be justifiable. Perhaps it is useful to compare the inevitability of risk when engaging in medical practice versus most other activities that might give rise to a GNM prosecution. The surgeon and anaesthetist do not take risks by choice, but by necessity, when the risks of the procedure exceed potential harm if it is not carried out. Conversely, the teacher who takes students swimming in a dangerous stream

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[90] See generally Skegg, above n 26; Danielle Griffiths and Andrew Sanders "The road to the dock: prosecution decision-making in medical manslaughter cases" in Amel Alghrani and Danielle Griffiths (eds) *Bioethics, Medicine and the Criminal Law. Volume 2: Medicine, Crime and Society* (Cambridge University Press, Cambridge, 2013) 117.

[91] Gareth Gillespie "Medicine and manslaughter" (6 May 2014) Medical Protection Society <www.medicalprotection.org>.

could have altered his plans, the only consequence being disappointing the children.[92] In an inherently risky environment with human lives at stake, it becomes more justifiable to treat doctors differently from other professions. As ss 150A–157 are applied to any person alleged to have negligently contributed to a death, not just doctors, this method does still risk incoherence in the GNM regime, as it would create different standards for different classes of people.

The demise of morbidity and mortality procedures discussed in Part III would still remain a threat under this current standard, even if guidance was provided as to the consideration of errors other than those of the accused doctor. If punishment under this new standard may still inhibit open disclosure and promote defensive medicine, but not deter or stop errors from occurring, then it is not enough to suggest that this change alone would remedy the serious problems identified in the United Kingdom cases.

B *A New Recklessness Standard?*

An alternative approach often proposed in the GNM context is changing the standard required for a conviction to one of recklessness. This would involve a higher threshold than the current gross negligence standard in both the United Kingdom and New Zealand. Proponents of this legal formula suggest that this would avoid making doctors culpable for mere errors or for situations involving a combination of medical error and systems failure. While it may appear that this view is somewhat radical, given the current trend towards professional accountability and patient rights, it is in accordance with traditional criminal law principles, most pertinently that the criminal law should only be invoked where there is mens rea.[93] It can also be argued that it is not, in any case, possible to deter inadvertence (or errors). Moreover, a requirement for subjective recklessness maintains coherence in the law of manslaughter regarding deterrence. It is particularly difficult to deter human error in a medical context where, as Quirk notes, doctors have a professional ethic to "first, do no harm".[94] The essential question is, therefore, does a person who acts

[92] Brazier, above n 4, at 30.

[93] McCall Smith, above n 5, at 131.

[94] Quirk, above n 74, at 871.

negligently, even in a gross fashion, manifest such a state of mind which justifies moral condemnation? This essay argues that the answer to this question should be firmly in the negative.

The proposal to change the standard to recklessness is not a new one, and the impetus for change has ebbed and flowed throughout the end of the 20th century and into the early 21st. Calls for the courts to recognise the standard as one of recklessness and not gross negligence have been rejected in cases such as *Adomako*, and no substantial reform to the law has been made by Parliament in New Zealand since the 1997 addition of the "major departure" standard. The United Kingdom Law Commission has made recommendations for the law to be amended, but these have not yet been adopted.[95]

The starting point in this discussion must be what the broad concept of negligence requires. An objectively-determined standard is applied, against which the conduct of the accused is measured. This standard is not defined according to an analysis of how people *typically* act. On the contrary, the standard is typically centred on a notion of how one *should* act to avoid adverse consequences.[96] It is inevitable that even the most skilled doctor will make an error of judgment or fail to do something that ought to have been done. There is a strong argument to make, then, that isolated incidents of failure to meet the current objective standard should not be considered morally culpable.

Adopting the recklessness standard would not mean that there are no errors that would result in culpability. If, for instance, a doctor has allowed herself to become distracted or has not allowed herself sufficient time to make a reasoned decision, blame is properly attributable to such errors in judgement. In these examples, the doctor made a conscious choice to conduct herself in such a way.[97] A deficiency in skill or training can also be culpable if a person who manifests ignorance is morally responsible for this state by failing to rectify an identified or obvious deficiency in her knowledge, if she knows that

[95] Law Commission (UK), above n 11.

[96] McCall Smith, above n 5, at 135.

[97] At 136.

the deficiency may cause harm to others. The deficiency in skill may equally come about through a failure to appreciate the limits of one's competence, where that person knows she does not possess the level of skill necessary to carry out particular procedures and proceeds in spite of that knowledge.[98]

An analysis of classic criminal law principles also leads to the conclusion that the standard ought to be set at recklessness. As McCall argues, the only state of mind which merits punishment in the criminal law is one which either indicates an intention to cause harm to others, or where there is conscious willingness to subject others to a risk of harm.[99] This discussion has been testing legal philosophers for some time. Indeed, Jerome Hall put a fine point on it by describing negligent criminal liability an "inordinately troublesome" area.[100] Hall's objection to negligent liability was a rejection of its unfairness due to the lack of mens rea element.[101] While some scholars such as H L A Hart defend some criminal punishment of negligence to encourage responsible behaviour, others such as Quick propose that the law of GNM as it is currently devised is incoherent and is particularly unjustifiable for professionals working in high-risk and unsafe systems.[102] Admittedly, the line between recklessness and gross negligence has been difficult to define at the best of times, and Quick's research into prosecutions for GNM in the medical context even revealed some prosecutors used the recklessness standard, a higher threshold than currently required, to measure whether prosecution was appropriate in the circumstances.[103] The question must then be asked whether, for certainty in the law as to what standard should properly be required for a GNM prosecution and for alignment of the law with traditional criminal law tenets, the standard should be raised to one of subjective recklessness.

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[98] McCall Smith, above n 5, at 134.

[99] At 137.

[100] Jerome Hall "Negligence and the General Problem of Criminal Resp" (1972) 81 Yale LJ 912 at 952 as cited in Oliver Quick "Medicine, Mistakes and Manslaughter: A Criminal Combination?" (2010) 69(1) CLJ 186 at 192.

[101] Similar views were expressed in J R Spencer and Marie-Aimeé Brajeux "Criminal Liability for Negligence – A Lesson from across the Channel?" (2010) 59 ICLQ 1 at 19.

[102] Quick, above n 100, at 192.

[103] At 193.

It is noted from various studies of prosecutions for medical manslaughter that in most there were questions of institutional systemic fault or the fault of at least one other person involved in the treatment of the deceased patient.[104] A new recklessness standard would not allow any more analysis of the contribution of systems failures to the outcome in a particular case than the existing gross negligence standard. Nevertheless, it may reduce the pool of people potentially culpable by limiting prosecution to instances where the accused has turned his mind to the risk of harm and has proceeded despite such a risk. As such, increasing the standard to avoid capturing conduct that involved even gross negligence with complicating factors of systems errors might avoid catching even a few instances where the system was at serious fault, as the recklessness requirement necessitates advertence as to risk. Under this proposed standard, conduct of the kind displayed by Sellu and Bawa-Garba would not be captured, as in neither case was there an allegation that the conduct was consciously reckless.

Raising the standard does involve the distinct possibility that the bar may be set *too* high. It is possible that doctors such as Keith Ramstead may escape liability, as while his conduct fit the gross negligence test, it might not have been possible to prove that he turned his mind to the possibility of risks and pursued the course of action regardless. Nevertheless, while the Ramstead-type doctor may walk free under this proposition, Blackstone's age-old formulation that it is better to have ten guilty persons escape punishment than one innocent one to suffer dictates that the focus must be on those deserving of protection from the scope of the criminal law, rather than those that are properly morally culpable but may escape by mere technicality.[105]

To further assuage concerns about the Ramsteads of the medical profession escaping liability, as outlined in Part I, there exist other accountability mechanisms other than manslaughter prosecution for doctors who fall below the standard expected of competent

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[104] Griffiths and Sanders, above n 90, at 602; Skegg, above n 26.

[105] Sir William Blackstone in W M Hardcastle Browne (ed) *Commentaries on the Laws of England In One Volume* (St Paul (United States), West Publishing Company, 1897) at 713.

practitioners.[106] For instance, while Ramstead may not have been successfully prosecuted, had this new formulation been the operative law at the time the case was decided it is very likely that a complaint would have been laid against him to the Health and Disability Commissioner. If the Commissioner concluded the Code had been breached, the Medical Council most likely would have instituted proceedings and laid charges against Ramstead before the HPDT. This may well have resulted in Ramstead being subject to restrictions on his practice, and even more likely still would have concluded with his name being struck off the medical register. This would have achieved the purpose of protecting the public from a substandard doctor and would have sent a clear message to the medical profession at large that the conduct Ramstead engaged in was not acceptable in New Zealand medical practice.

VI Conclusion

The standard that should be adopted in New Zealand to avoid the occurrence of a similarly problematic prosecution for GNM is a subjective recklessness standard. This remedies many of the concerns around the current GNM standard and, while risking allowing some morally blameworthy actors walking free without being prosecuted, other disciplinary and regulatory measures exist to catch conduct of this nature. While prosecutions of doctors for GNM have been scarce in New Zealand in the 20th century, that is not to say that one is not possible. Given the similarity of the New Zealand law to the United Kingdom's, there is a very real possibility of a case like Sellu's or Bawa-Garba's occurring in this jurisdiction. The problems these cases raise indicate that it is indeed necessary to make a change, and the most effective and coherent change to make is to raise the standard.

To effect such a change would most likely require Parliament to intervene, as the courts have been reluctant to move in this direction. Indeed, the courts have universally refused to recognise that the gross negligence standard contemplates reckless conduct, for example in *Adomako*. It is unclear how likely reform in this area would be to occur.

[106] This view is supported by Quirk, above n 74.

Raising the standard may require an effort comparable to the New Zealand Medical Law Reform Group's campaign to change the standard from ordinary to gross negligence in order to sufficiently indicate impetus for change. Nevertheless, it is clear that by favouring such a change, Parliament would be clarifying a previously confusing and inconsistent standard and would be aiming the law at the correct level of moral blameworthiness.

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VIII Word Count

The text of this paper (excluding abstract, table of contents, footnotes, and bibliography) comprises approximately 7,995 words.