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***R v Southampton* and Fatal Medical Negligence: An Anomaly or a Sign of Things to Come?**

Dr. Gavin Ruddy

Abstract

A review of statistics concerning fatal medical negligence in the NHS shows that, despite fears of a 'compensation culture' and the right to life protected by Human Rights legislation, only about one in every 1,000 such cases is investigated by the courts. This appears to be largely due to very poor reporting of adverse incidents by health authorities. However, as a result of recent healthcare scandals, the reporting of incidents is expected to significantly increase in the near future. The case of *R v Southampton University Hospitals NHS Trust* 2006 illustrates the striking effect that enhanced levels of scrutiny can have in these cases. While there was nothing extraordinary in the facts of this case, and the hospital's safety record did not appear to be any worse than average, the doctors involved were convicted of gross negligence manslaughter and the hospital was heavily fined under Health and Safety legislation for systemic failures. *R v Southampton* demonstrates that poor hospital systems are not immune from legal action in cases of fatal medical negligence, and recent developments suggest considerable potential liability for the NHS in this respect.

Keywords: Fatal Medical Negligence, Gross Negligence Manslaughter, Health and Safety, Corporate Manslaughter

1 The Significance of *R v Southampton University Hospitals NHS Trust*

At Winchester Crown Court in 2006, Judge Michael Broderick declared that the case before him had implications for the whole NHS,¹ and it certainly looked that way. The case concerned the death of 31-year-old Sean Phillips from infection shortly after a routine tendon operation in a hospital run by Southampton University Hospitals NHS

¹ BBC News, 'Trust guilty over death doctors,' 11/1/2006, <http://news.bbc.co.uk/1/hi/england/hampshire/4602228.stm> (accessed 24/2/2010).

Trust. The two junior doctors responsible for Mr. Phillips' poor aftercare had been convicted of gross negligence manslaughter.² Over a weekend shift, they had missed the diagnostic signs, failed to seek advice, chase up results or administer antibiotics, and this had resulted in Mr. Phillips' untimely death. The finding of gross negligence manslaughter had been dramatic, since the failures in care had arguably fallen short of the gross negligence in *Adomako*,³ and not that far beyond the inept, but non-criminal, medical negligence of *Prentice and Sullman*.⁴

However, the remarkable feature of the case was that the Trust then found itself in the dock for failing to properly supervise the doctors at the time. This was quite unlike any other cases of fatal medical negligence.⁵ A civil compensation claim under the Fatal Accidents Act 1976 is the norm, and, in a few exceptionally serious cases, the staff involved might face professional sanctions or criminal charges.⁶ Here, poor hospital systems, generally regarded as the root cause of most medical errors⁷ but usually beyond legal action,⁸ were also being held to account. The Trust pleaded guilty to one of the five charges brought against it under s.3 Health and Safety at Work Act 1974 (HSWA), on the basis that the other four charges would be dropped and that the admitted failing had not actually caused Mr. Phillips' death. In this way, the Trust hoped to avoid liability under common law corporate manslaughter that might have otherwise applied at that time. In spite of the plea bargain, the hospital was fined an unprecedented £100,000, and this attracted considerable adverse publicity and comment.⁹

So, *R v Southampton*¹⁰ looked set to make aspects of 'system failure' in the NHS actionable, opening the door to the possibility of corporate manslaughter.¹¹ Certainly, the

² *DPP v Misra and Srivastava*, Winchester Crown Court, 11/4/2003, unreported.

³ *R v Adomako* [1995] 1 AC 171.

⁴ *Ibid*, and *R v Sullman* [1994] QB 302.

⁵ Quick, O., 'Prosecuting Medical Mishaps,' (2006), 156(7215), *New Law Journal*, 394-395.

⁶ Wheeler, R., 'Medical Manslaughter: why this shift from tort to crime?' (2002), 152(7028), *New Law Journal*, 593-594.

⁷ See for example, Department of Health, *An Organisation with a Memory* 6 June 2005.

⁸ Harris, A., 'Don't Blame Me,' (2008), 158(7316), *New Law Journal* 499-500.

⁹ Samanta, A. and Samanta, J., 'Charges of Corporate Manslaughter in the NHS,' (2006) 332, *British Medical Journal*, 1404-1405.

¹⁰ *Health and Safety Executive v Southampton University Hospitals NHS*, Winchester Crown Court 11/4/2006 (unreported), later appealed in *R v Southampton University Hospitals NHS Trust* [2006] EWCA Crim 2971.

judgment implied that hospitals would now find it much harder to escape liability for poor care by letting individual (often junior) staff take all the blame, and this was widely regarded as an important step forward in forcing better learning from adverse incidents in the NHS.¹² Subsequently, both the gross negligence manslaughter by the doctors and the 'almost' corporate manslaughter by the Trust were appealed,¹³ with limited success, adding further to the judicial significance of the cases.

Despite a large number of similar deaths in the NHS each year,¹⁴ frequent poor healthcare scandals,¹⁵ significant financial problems for the NHS from civil litigation,¹⁶ and an apparently positive legal way forward provided by *R v Southampton*, why have so few similar actions been brought since?

2 How Many Fatal Medical Negligence Cases Make it to Court?

The National Audit Office estimates that there are up to 34,000 deaths a year in the NHS due to medical error.¹⁷ This is consistent with the results of most medical case note review studies,¹⁸ and constitutes the third most likely cause of death in the UK after heart disease and cancer. This information came as a surprise to the Commons Health Select Committee¹⁹ when the Mid-Staffordshire scandal broke in 2008. It became apparent during the Committee's inquiries that on average only 5 to 10% of medical accidents were being reported even within the NHS,²⁰ and that the more serious the incident, the

¹¹ Samanta and Samanta, 'Charges of Corporate Manslaughter in the NHS'.

¹² See for example discussion in Quick, O., 'Outing Medical Errors: questions of trust and responsibility,' (2006), 14(1), *Medical Law Review* 22-43.

¹³ *R v Misra* [2004] EWCA Crim 2375 and *R v Southampton University Hospitals NHS Trust* [2006] EWCA Crim 2971.

¹⁴ See below.

¹⁵ For example, Sarah Boseley, 'Mid Staffordshire managers must answer for hospital failures – Brown,' *The Guardian*, 24/2/2010.

¹⁶ For example, Kate Devlin, 'NHS compensation bill could be £12 billion.' *The Telegraph*, 15/10/2008.

¹⁷ National Audit Office, *A Safer Place for Patients: Learning to improve patient safety*, 2005.

¹⁸ For example, Vincent, C. *et al*, 'Adverse Events in British Hospitals', (2001), 322, *British Medical Journal*, 517-519.

¹⁹ Rebecca Smith, 'Nine out of ten preventable deaths in the NHS are not reported', *The Telegraph*, 30/10/2008.

²⁰ *Ibid*.

less likely it was to be reported at all.²¹ As if to reinforce the point, it emerged that questions of poor care at Mid-Staffordshire had not arisen from within the NHS itself (which regarded Mid-Staffordshire as exemplary at the time²²), but because quasi-independent researchers at Imperial College²³ noticed the high mortality rates and informed the Healthcare Commission,²⁴ who then took the opportunity to cause a fuss immediately before being disbanded by the Secretary of State for Health. While excess mortality at Mid-Staffordshire may or may not prove to be an isolated problem, it is clear that poor reporting reflected much wider and longer-term problems in the NHS, in particular the push for independence from Strategic Health Authorities²⁵ that had historically provided some on-the-spot regulation.²⁶

In the absence of adequate reporting and detailed analysis, the extent to which death due to medical error is equivalent to medically negligent death is not entirely clear. By definition though, each death by medical error identified in medical case note review studies involves a duty of care, and *Bolam*²⁷ type breach and causation - that is breach and causation judged by the standards of other doctors. Since this is the test used in court, 34,000 deaths a year may not be an unreasonable estimate. It is sometimes argued, however, that the review studies approach may overestimate the true extent of medically negligent death,²⁸ since medical causation is rarely straightforward. The classic complication scenario in *Wilsher v Essex AHA*²⁹ is often cited in this respect. The case involved five independent possible causes of the same blindness in a patient, only one of which involved a breach of duty, and this resulted in the claimant being unable to

²¹ Ali Baba-Akbari Sari *et al.*, 'Extent, nature and consequences of adverse events: results of a retrospective casenote review in a large NHS hospital,' (2007), 16, *Quality and Safety in Health Care*, 434-439.

²² See Thompson, G., 'Mortality rates at Mid-Staffordshire Foundation Trust,' *House of Commons Library* SN/SG/5030, for an interesting then and now comparison.

²³ The Dr. Foster Unit, at <http://www.drfoosterintelligence.co.uk>.

²⁴ Part of the NHS; now replaced by the Care Quality Commission, which acts in a similar capacity, but with the power to investigate problems removed.

²⁵ Strategic Health Authorities are regional health authorities that hold the purse strings for those NHS Trusts that have not yet achieved Foundation status.

²⁶ For example, Serious Untoward Incident reporting in Trusts no longer requires the involvement of Strategic Health Authorities.

²⁷ *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118.

²⁸ See Professor Thompson's responses to Sarah Gidely's questions in the Commons Health Select Committee on Patient Safety 20/11/2008 <http://www.publications.parliament.uk/pa/cm200708/cmselect/cmhealth/uc1161-ii/uc116102.htm> (accessed 28/2/2010)

²⁹ [1988] AC 1074.

demonstrate, on the balance of probabilities, that the defendant Health Authority had caused the damage. On the other hand, the National Audit Office point out that a further 25,000 deaths a year are caused by thromboembolisms,³⁰ many of which are the avoidable results of other earlier healthcare interventions, so the true extent of the problem may be even larger.

No matter what the precise mortality figure is, there is certainly an extremely large disparity between rates of medical negligence and the number of cases that are litigated or compensated. The NHS Litigation Authority (NHSLA) indemnifies Trusts against negligence claims,³¹ and despite widespread fear of a compensation culture,³² the NHSLA deals with little more than 6,000 claims per year in total.³³ This is a very low number compared to the 850,000 medical errors that the NHS itself estimates occur each year.³⁴ In 2008, just 743 of NHSLA claims involved the death of a patient,³⁵ and in at least some, the death itself was incidental to the claim. Of all claims received by the NHSLA in 2008, 48% were abandoned during the claims process and 49% were settled out of court by Part 36 Offers,³⁶ leaving something like 200 medical negligence cases to be heard in court each year. This estimate is likely to be approximately correct, since it is similar to the total number of clinical negligence cases heard at the Queen's Bench each year.³⁷ On the basis of the NHSLA statistics above, about 10% of these cases involve a fatality.

As was made clear by *Takoushi*,³⁸ under Article 2 European Convention on Human Rights (ECHR), the state has an obligation to provide a practical and effective judicial system for the determination of civil liability and for the investigation of the facts of a death in which medical negligence may have been involved. This is sometimes referred

³⁰ *A Safer Place for Patients: Learning to improve patient safety.*

³¹ Including relatively low value compensation claims that might fall within the NHS Redress Act 2006.

³² For example, see ss 1 and 2 Compensation Act 2006.

³³ NHSLA, Factsheet 3: Information on Claims, available at <http://www.npsa.com>

³⁴ National Patient Safety Agency, *Reporting and Learning System, Quarterly Data Summary*, November 2008.

³⁵ Response to Freedom of Information request to the NHSLA, dated 29/9/2009.

³⁶ National Patient Safety Agency, *Reporting and Learning System, Quarterly Data Summary*, adjusted to remove unsettled claims. Part 36 offers are compensation offers made under the Civil Procedure Rules 1988.

³⁷ Ministry of Justice, *Judicial and Court Statistics 2008.*

³⁸ *R (ex parte Takoushis) v HM Coroner for Inner North London* [2005] EWCA Civ 1440.

to as the procedural obligation of Article 2. Internal investigations by the authorities involved in the death are not held to be sufficient (see *JL*³⁹). In *Takoushis*, the Court of Appeal held that Article 2 is discharged under English law by a combination of a Coroner's Inquest and civil action, and that no additional judicial inquiries are required. Inquests might therefore be expected to fulfil an important function in the investigation of medically negligent deaths.⁴⁰ It appears, however, that the number of enhanced 'Article 2 engaged' inquests is very low, with Coroners' investigations for the most part restricted to the narrow *Jamieson*⁴¹ inquiry (a literal how the deceased came by their death) and by rules 36 and 42 of the Coroners Rules 1984 (a duty to avoid issues of civil liability). Statistics concerning inquests in relation to the NHS are difficult to find, but the Ministry of Justice estimates that about 460 a year⁴² involve medical defence organisations, which provide legal representation for medical staff where questions of liability are likely to be raised. Another indication that the number may be very low comes from the Coroners (Amendments) Rules 2008, which now allow Coroners to produce Rule 43 Reports to prevent future deaths. In their first year of operation, just 58 reports were issued in relation to hospital deaths.⁴³

In spite of the procedural obligation then, the figures suggest that only about 1 in every 1,000 medically negligent deaths is currently investigated in the courts. The apparently small number of relevant inquests implies that this may be largely due to poor reporting of medical error by the NHS, even to the Coroner's Office. Other factors are also likely to be important in keeping legal action to a minimum. For example, it may be that the high rate of abandoned NHSLA claims is caused by the obvious difficulty in bringing a claim where the burden is entirely on the claimant to demonstrate that medical negligence has occurred, usually without access to either the expertise or the information that are available to the defendant hospital. Where causation is clear-cut, Part 36 Offers made by the NHSLA also have the effect of keeping a case out of the courts. This is because the Civil Procedure Rules mean that bereaved families risk liability for costs if an appropriate

³⁹ *R (ex parte JL) v Secretary of State for the Home Department* [2009] 1 AC 588.

⁴⁰ For example, see discussion in Powers, M.J. QC, 'Patient Safety – A Personal View' http://www.medneg.co.uk/patient_safety.htm (accessed 2/3/2010)

⁴¹ *R (ex parte Jamieson) v HM Coroner for North Humberside and Scunthorpe* [1995] QB 1.

⁴² Estimated on the basis of <http://www.justice.gov.uk/publications/docs/coroners-justice-letters-stakeholders.pdf> (accessed 1/3/2010)

⁴³ Ministry of Justice, *Summary of Reports Under Rule 43 of the Coroners Rules*, July 2009.

offer is made and not accepted.⁴⁴ The Human Rights cases of *Powell*⁴⁵ and *Calvelli*⁴⁶ show that once these sorts of offers have been made, the courts will regard the matter as settled.

So, only about 20 cases of fatal medical negligence will make it into the courts each year. Given this low number, it is perhaps not surprising that there are few criminal indictments of professionals for poor care, since the standard of proof required for gross negligence is so much greater than that required for civil negligence. There are obviously also fairly strong policy considerations involved in attempting to regulate public authorities by the criminal prosecution of individuals,⁴⁷ all of whom are already theoretically regulated by bodies with statutory powers such as the General Medical Council. As far as HSAW convictions for patient deaths in hospital trusts are concerned, there have been just seven since 1999,⁴⁸ almost half of which involved falls from unsecured windows.

3 What Made *R v Southampton* so Unusual?

In terms of medical negligence, there was nothing particularly extraordinary in the facts of *Misra and Srivastava*,⁴⁹ the two junior doctors involved in Mr. Phillips' death. The death occurred on the Tuesday, and the doctors had worked the alternate shifts on the weekend immediately preceding it. During these shifts, both had failed to diagnose and therefore treat serious infection, although each had reviewed the patient on a number of occasions. There was no evidence of infection in the operation scar (even at post mortem), and there was evidence to suggest that Mr. Phillips' problems may have been secondary to a minor gastro-intestinal infection,⁵⁰ for which he was receiving some treatment and being observed. He remained alert and aware for the whole weekend.

⁴⁴ Rule 36.10(1).

⁴⁵ *Powell v United Kingdom* (2000) 30 EHRR CD 362.

⁴⁶ *Calvelli and Ciglio v Italy* Reports of Judgments and Decisions 2002-I, p25.

⁴⁷ Brazier, M. and Alghrani, A., 'Fatal medical malpractice and criminal liability', 2009, 25(2), *Professional Negligence*, 51-67.

⁴⁸ See HSE Public Register of Convictions at http://www.hse.gov.uk/prosecutions/case/case_list.asp?ST=C&SF=SIC&SN=F&EO=%3D&SV=85111++++&SO=AODS (accessed 16/03/2010)

⁴⁹ *R v Misra*.

⁵⁰ *R v Misra*, at pp.10 and 15.

At trial, however, the expert medical opinions felt that the doctors should have diagnosed the more serious infection, and agreed that by sometime on the Sunday afternoon Mr. Phillips' septicaemia would have been too well developed to respond to antibiotics. It seems to have been the blood sample taken by a third doctor on the Saturday evening that tipped the balance from possible medical negligence into gross negligence manslaughter. The fact that this blood sample was taken demonstrated that Mr. Phillips' symptoms suggested more serious problems, and the results indicated that a more serious infection was indeed involved. However, no one had accessed the results until Sunday night, by which time (in retrospect) it was too late.

The offence of gross negligence manslaughter requires that there is a breach of duty that exposes the victim to risk of death, that this breach causes the victim's death, and crucially that the breach is so grossly negligent that it is consequentially a crime.⁵¹ This is the gross negligence test based on *Bateman*⁵² that was approved by the House of Lords in *Adomako*.⁵³ In this situation, the necessary mens rea is provided by virtue of the negligence being gross, and questions of recklessness do not arise. Hence, in considering conviction, the jury at Winchester Crown Court were deciding whether failing to diagnose the infection fell so far short of acceptable medical standards that it constituted a serious criminal offence. While those acceptable standards were determined with reference to the expert medical opinions, it was the jury who found the doctors guilty. In this sense, the gross negligence test may sometimes set a lower hurdle than even normal *Bolam*⁵⁴ negligence.

Misra and Srivastava's appeal⁵⁵ followed in October 2004. They claimed that they had been acting in good faith at the time, and hence should not be guilty of a crime. They claimed that fresh expert evidence introduced new doubt into the issue of causation. The main contention, however, was that the offence itself, determined as it was by the jury, was sufficiently uncertain to contravene ECHR Articles 6 and 7.⁵⁶ Ultimately, the Court of Appeal dismissed each argument, upholding the convictions and suggesting

⁵¹ The Law Commission, *Involuntary Manslaughter*, (Law Com No.237) 1996, s.3.7-3.9.

⁵² *R v Bateman* (1927) 19 Cr App R 8.

⁵³ *R v Adomako*.

⁵⁴ *Bolam v Friern Hospital Management Committee*.

⁵⁵ *R v Misra*.

⁵⁶ The right to fair trial, and the principle of legal certainty, respectively.

that the offence laid out in *Adomako*, while containing a well-known element of circularity,⁵⁷ did not conflict with the ECHR and should be regarded as clear enough.

Having so conclusively and completely laid responsibility for Mr. Phillips' death at the feet of the two junior doctors, it might seem surprising that by November 2005, the Trust was in Winchester Crown Court again for having failed in its duty of care to Mr. Phillips, this time under s.3 HSAW. After all, if unsafe systems at the hospital were also partly responsible for Mr. Phillips' death, then the junior doctors' individual culpability may have been over-estimated.

Section 3 of the 1974 Act imposes a duty on institutions to take all reasonable practical steps to ensure that visitors, in this case patients, are not exposed to risks to their health and safety, and s.33(1) makes it an offence where there is a breach of s.3. The initial allegations against the Trust included general problems (for example, failing to organise ward rounds and hand-over meetings, and poor systems for reporting concerns to consultants), as well as failings more specifically related to the incident, such as failing to take up a reference for Dr. Misra.⁵⁸ Of these, only failing to properly supervise the junior doctors was actually charged - as mentioned earlier, on the basis that it had not actually caused Mr. Phillips' death. It became apparent that there had been concerns about the unit prior to the incident, including reporting and supervision issues, and a problem with Dr. Misra's treatment of another patient that was brought to the attention of a senior consultant just the day before the death.⁵⁹ The consultants running the unit also admitted that they had virtually no contact with the junior staff, depending on registrars to flag up any problems, and that some priorities and guidelines had been neglected given the pressures on the unit. Although these are to some extent problems facing most units in most hospitals, it was quite clear that grounds for the action existed.

In bringing the action when they did, the Health and Safety Executive (HSE) may have felt that the manslaughter convictions would add some extra weight to their case against the Trust, but these were in no way a prerequisite. Damage is not required to make a breach of s.3 actionable, simply exposing the public to a risk by failing to take

⁵⁷ *R v Misra*, at p.28.

⁵⁸ BBC News, 'Trust guilty over death doctors', and Quick, 'Prosecuting medical mishaps.'

⁵⁹ *R v Southampton University Hospitals NHS Trust*, pp.3-12.

reasonable practical steps to mitigate it is sufficient, provided that there can be said to have been fair notice.⁶⁰ In *R v Board of Trustees of the Science Museum*,⁶¹ the Court of Appeal made it clear that any such risk where reasonable steps had not been taken would be considered a breach of s.3, regardless of the scale. The position vis-à-vis the risk may have narrowed recently, when the situation was again spelled out in *R v Chargot*.⁶² Here the issue of whether an injury might demonstrate a failing in health and safety arose. The House of Lords held that it did not; the key point was showing that a breach of duty had occurred, whether or not injury had resulted. This might, however, mean that the prosecution would now have to be fairly specific about the details of a breach in the absence of injury,⁶³ but in the context of *R v Southampton*, whether the doctors were convicted of gross negligence manslaughter or simply of medical negligence would have made no legal difference to the Trust's breach of s.3. The HSE therefore could have brought the action at any stage.

Although at appeal,⁶⁴ one of the Trust's contentions was that Broderick J had ignored the basis of the guilty plea (that the breach had not resulted in the death), the appeal court maintained that the breach had been 'very serious,' and pointedly only dealt with the issue of the size of the fine imposed. The various mitigating and aggravating factors from *R v F Howe and Son*⁶⁵ were discussed, with the guilty plea, early remedial action and the Trust's apparently good safety record being held up in defence. The fine for a HSAW breach is designed to be a punitive measure (and can now be unlimited⁶⁶), but the Trust argued that £100,000 was disproportionate for the NHS, where this money would have to be found from budgets providing healthcare. Hence, as a public authority, *R v Milford Haven Port Authority*⁶⁷ was applied and the court reduced the fine to £40,000 plus costs.

Given that the HSE action followed on from the negligence action, perhaps the most important element of *R v Southampton* is that it demonstrates how much information regarding the circumstances of Mr. Phillips' death probably came to light as a result of

⁶⁰ *Adamson v Houston* [2000] GWD 38-1428.

⁶¹ [1993] 3 All ER 853.

⁶² *R v Chargot Ltd (t/a Contract Services)* [2009] 1 WLR 1.

⁶³ *R v Chargot*, at 22.

⁶⁴ *R v Southampton University Hospitals NHS Trust*.

⁶⁵ [1999] 2 All ER 249.

⁶⁶ Health and Safety (Offences) Act 2008, Schedule 1.

⁶⁷ [2000] 2 Cr App R (S) 423.

the gross negligence manslaughter investigations.⁶⁸ It seems that there was nothing intrinsically unusual in the facts of the case. The death was one of a large number that happen every year. The junior doctors may have been negligent in their treatment, but arguably not much more grossly than in many other cases. The unit where they worked was over-stretched and less well organised than some, but not apparently unsafe compared to the average. What made *R v Southampton* unusual was the scrutiny it received. This may have been more to do with incidental features of the case than the determination of the various authorities involved. For example, it is an uncomfortable feature of *Misra and Srivastava* that by a majority, the Winchester jury convicted two junior doctors from a different ethnic background for the negligent death of a healthy, white, local, 31-year-old new father.

4 Developments Since *R v Southampton*

The scarcity of cases like *R v Southampton* in an area where there are clearly major problems, illustrates the mountain the NHS has to climb to achieve the sort of efficient learning from adverse incidents set out in policies like 'Being Open.'⁶⁹ If some element of scandal is required to bring out the necessary details from which to learn lessons, then there is no shortage on the horizon. The German out-of-hours locum Dr. Ubani,⁷⁰ the Mid-Staffordshire inquiries⁷¹ and the problems at Basildon and Thurrock University Hospitals NHS Foundation Trust⁷² to name a few.

The recent cases of *Bailey*⁷³ and *Canning-Kishver*⁷⁴ suggest that there may also have been some potentially very significant developments in the area of material contribution, simplifying to some extent the complex causation issues that are a feature of medical

⁶⁸ Quick, 'Prosecuting medical mishaps'.

⁶⁹ See <http://www.nrls.npsa.nhs.uk/resources/?entryid45=65077> (accessed 4/3/2010).

⁷⁰ Meikle, J., 'Overdose inquest finds German doctor Daniel Ubani incompetent', *The Guardian*, 4/2/2010.

⁷¹ *Independent Inquiry into care provided by the Mid Staffordshire Foundation Trust January 2005 – March 2009*, Robert Francis QC, 24/2/2010. Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113018 (accessed 26/2/2010).

⁷² BBC News, 'Patient death charge hospital admits safety law breach', 26/2/2006, <http://news.bbc.co.uk/1/hi/england/essex/8538676.stm> (accessed 4/3/2010).

⁷³ *Bailey v Ministry of Defence* [2008] EWCA Civ 883.

⁷⁴ *Canning-Kishver v Sandwell and West Birmingham NHS Trust* [2008] EWHC 2384 (QB).

negligence actions.⁷⁵ The Corporate Manslaughter Act 2007 is also now in force, and this was expressly designed to overcome some of the problems that exist in making organisations liable for negligent deaths.⁷⁶

However, it may be the development of a 'duty of candour' for the NHS that will have the most far-reaching effect. Draft regulations now before Parliament⁷⁷ will oblige all healthcare providers to report adverse incidents to the National Patient Safety Agency from April 2010. While this falls somewhat short of what campaigners had hoped to achieve (a duty of candour in addition to patients or their relatives⁷⁸), it is likely to significantly increase the number of cases that receive some legal attention. At least some of these cases will involve a similar *R v Southampton* domino effect, and we can expect to see failing healthcare systems in the dock much more often in the near future. Indeed, the HSE has very recently charged two new breaches of s.3 in connection with deaths in hospitals; those of Kyle Flak at Basildon and Thurrock⁷⁹ and Mayra Cabrera at the Great Western Hospital.⁸⁰

⁷⁵ Gibson, C., 'Material contribution causation in clinical negligence cases,' 2008, 14(6), *The AVMA Medical & Legal Journal*, 239-242.

⁷⁶ For example, Hsiao, M., 'Abandonment of the doctrine of attribution in favour of gross negligence test in the Corporate Manslaughter and Corporate Homicide Act 2007,' 2009, 30(4), *Company Lawyer* 110-112.

⁷⁷ Campbell, C., 'Crackdown will force hospitals to log all lapses', *The Observer*, 6/12/2009.

⁷⁸ See Action against Medical Accidents press release, 6/12/2009
http://www.avma.org.uk/data/files/avma_press_release_reporting_adverse_events_to_be_mandatory.pdf (accessed 6/3/2010).

⁷⁹ Denis Campbell, 'Hospital admits criminal failure after disabled patient choked to death' *The Guardian*, 26/02/2010.

⁸⁰ <http://www.nursingtimes.net/nursing-practice-clinical-research/clinical-subjects/patient-safety/trust-admits-guilt-after-nurses-drug-error-kills-patient/5012352.article> (accessed 16/03/2010).