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Dear Mr Williams

OPERATION ROCHESTER

Thank you for your letter of 27 July 2004 together with the enclosures. I have now had an opportunity to discuss the issues with Paul Close and with Louise Povey of the GMC.

I turn first to the issue of the proposal to disclose material to the GMC relating to the 60 or so cases assessed as sub-optimal care. The potential concerns so far as the CPS are concerned relate of course to what impact such disclosure, if you decide to make it, might have of any future prosecution and whether it might prejudice any trial.

I have spoken with Louise Povey, and she informs me that her advice to the GMC will be that the material under consideration should be used to base an investigation for submission to the Interim Orders Committee. That committee sits in private and it would be her advice that no further disciplinary proceedings, which would of course be public, should follow until the police investigation and any trial have been completed. I indicated to her that my main concern was that there should be no adverse publicity in the period immediately before or during the criminal proceedings, if such proceedings are commenced. I asked that should any decision be contemplated that was contrary to the proposed course outlined above then advance notice should be given to you so that appropriate representations could be made regarding postponement.

One additional matter that I raised with her concerned any investigation that they undertook following the disclosure. I pointed out that any statements obtained from persons who were subsequently witnesses in any criminal trial would be potentially disclosable. I indicated that she should liaise with you to ascertain whether those they proposed to see were potential witnesses.

Finally, you will no doubt have arranged to take all appropriate steps to ensure that any necessary permissions are obtained from interested parties before their statements and or records are disclosed to another agency.

In summary, I do not consider that, in the circumstances outlined above, there are any substantial reasons so far as the CPS are concerned which should prevent you from making the disclosure that you propose.

I turn now to the proposed guidance to the medical experts and I offer the following comments:

Overview

In the second paragraph it is inappropriate to ask the experts to give an opinion on, "the extent to which [the care provided] may or may not disclose criminally culpable actions …". What would be permissible and desirable is an opinion as to how far below acceptable standards or practice the care falls.

Similarly, at paragraph four, it is not admissible for the expert to give an opinion as to whether the defendant "intended to hasten or end life". Any opinion should be limited to for example, stating that it would have been obvious to the reasonably prudent and skillful doctor in the defendant's position that their actions would hasten or end life.

In describing the standard of proof required for the prosecution to prove its case at paragraph numbered 4), the following alternative wording is suggested:

When reading the statements of the experts the prosecutor will be looking to apply the criminal standard of proof namely, the evidence to prove any element of the offence must be sufficient to satisfy the jury so that they are sure, or satisfied beyond reasonable doubt. Experts should bear this in mind when expressing opinions or findings so that it is clear as to the level of certainty they can give. Is it for example, only to the level of more likely than not (i.e. on the balance of probabilities), or to the higher level, of being sure so that other reasonable possibilities can be excluded.

There is the word 'have' missing from the first line of the paragraph numbered 1).

I set out below suggested guidance on the offences to be considered. It is somewhat longer than the original draft but I consider that the additional material is highly relevant to the issues we wish the experts to address, without I hope being too technical.

UNLAWFUL ACT MANSLAUGHTER

'Unlawful act' manslaughter requires that:

(a) the killing must be the result of the accused's unlawful act, though not his unlawful omission. It must be unlawful in that it constitutes a crime. A lawful act does not become unlawful simply because it is performed negligently. The act must be a substantial (more than minimal) cause of death, but not necessarily the only operative cause (see "Causation" below);

(b) the unlawful act must be one, such as an assault, which all sober and reasonable people would inevitably realise must subject the victim to, at least, the risk of some harm resulting there from, albeit not serious harm;

(c) it is immaterial whether or not the accused knew that the act was unlawful and dangerous, and whether or not he intended harm; the mental state or intention required is that appropriate to the unlawful act in question; and

(d) "harm" means physical harm.

(Church [1966] 1 QB 59, DPP v Newbury [1977] AC 500, Goodfellow (1986) 83 Cr App R 23)

GROSS NEGLIGENCE MANSLAUGHTER

"Gross negligence" manslaughter requires the satisfaction of a four stage test:

(a) The existence of a duty of care owed by the defendant to the deceased;

(b) A breach of that duty of care, which

(c) Causes (or significantly contributes to) the death of the victim (see "Causation" below);

(d) And the breach should be characterised as gross negligence and therefore a crime.

(Adomako [1994] 3 All ER 79)

The standard and the breach are judged on the ordinary law of negligence. Those with a duty of care must act as the reasonable person would do in their position. The test is objective. It does not matter that the defendant did not appreciate the risk, provided that such a risk would have been obvious to a reasonable person in the defendant's position. The risk in question is a risk of death.

MURDER

Murder is the unlawful killing of a person with the intention to kill or cause grievous bodily harm. Nothing less will suffice. Foresight that a consequence is almost certain to result is not the same as intention, though it may be evidence of it. There is some legal authority for the proposition that, where the sole, bona fide intention of a doctor is the relief of pain through the administration of drugs, knowledge that those drugs will, as an unwanted side effect, also inevitably hasten the patient's death, that is not murder.

CAUSATION

When prosecuting for an offence of homicide, there are a number of elements the Crown has to prove, and has to prove them to the criminal standard i.e. 'beyond reasonable doubt.' One of those is the element of 'causation'. In simple terms this means that the prosecution must prove that the death was 'caused' (wholly or in part) by the defendant and ought to be straightforward but, '(W)here the law requires proof of the relationship between an act and its consequences as an element of responsibility, a simple and sufficient explanation of the basis of such relationship has proved notoriously elusive.' - *R v Cheshire* [1991] 3 All ER 670.

Recent experience has identified causation as a difficult element to prove in certain types of cases. These are typically, but not exclusively, cases involving medical negligence.

The classic statement on causation in manslaughter was provided by the present Lord Chief Justice in *R v HM Coroner for Inner London, ex parte Douglas-Williams* (1998) 1 All ER 344:

"...that the unlawful act caused death in the sense that it more than minimally, negligibly or trivially contributed to the death.

"In relation to both types of manslaughter it is an essential ingredient that the unlawful or negligent act must have caused the death at least in the manner described. If there is a situation where, on examination of the evidence, it cannot be said that the death in question was [not] caused by an act which was unlawful or negligent as I have described, then a critical link in the chain of causation is not established. That being so, a verdict of unlawful killing would not be appropriate and should not be left to the jury."

(There is an additional 'not' [now in brackets] in the penultimate sentence, otherwise the sentence does not make sense.)

It can be seen from this that the prosecution **must** be able to link the act to at least **an** operative cause of death. It is not sufficient to say that it **may have been** a cause of death.

Hastening/acceleration of death

This can be one of the most difficult aspects of causation. The 'hastening' or 'acceleration' of death and whether depriving a person of the opportunity to live can be a cause of death.

Death is inevitable. Any **action** that brings that day forward can therefore be said to have hastened or accelerated death and will itself be a cause of death. The case most often cited for such a proposition is *R v Dyson* [1909] 1 Cr App R 13. There the defendant had assaulted a child in November 1906 and December 1907. The child died in March 1908 but the charge of manslaughter did not specify the date of the assault (the 'year and a day' rule was then in force.) The child's condition had deteriorated as a result of the 1906 assault but the court said that the judge should have directed the jury to consider 'whether the appellant accelerated the death by his injury of December 1907'. In allowing the appeal the court said that 'it was not absolutely certain that the death had been accelerated' by the second assault as 'death may have been due to a fall'.

This is not a controversial proposition as it is simply a question whether the later act of the defendant brought about the death. Even if the deceased is dying (subject to the *de minimis* rule in *Sinclair*), if the defendant's act shortens life, causation is proved.

De minimis

It would not be sufficient to prove causation if the Crown could only show that the victim would have survived 'hours or days in circumstances where intervening life would have been of no real quality.' It is this meaning that is taken when referring to the *de minimis* rule. For example, if 'V' is dying, is in a coma, on life support and the defendant's act or omission brings forward the date of that inevitable death by hours or even days, if it can be said that there was 'no real quality' of life in that intervening period, the *de minimis* rule would apply. This is to be contrasted with a situation whereby the act or omission caused the coma and ensuing death or where there was a significant period between the act or omission and the ensuing death. It is not possible to be more definite as to the duration here but if 'V' survived in that state for more than a few days, *de minimis* would not apply and the ordinary rule of causation would do so instead.

Multifactorial
The insuperable difficulty comes when the doctors cannot say when or even if he may have died even if treated appropriately. This may be because they do not know the underlying cause of the illness or there are numerous factors present at death and it is not possible to identify which, if any had an operative influence on the death. In instances such as these, the death may be certified as 'multifactorial'. Although such a term should provide a warning to a prosecutor as to proof of causation, it does not necessarily mean that we cannot prove causation. If we can prove that one of the operative causes of death was due to the act or omission of the defendant, then this is sufficient to prove causation. Causation does not require that the particular cause would have caused death on its own, provided it is sufficient to be an operative **contribution** to the cause of death. Therefore, if the doctor in citing 'multifactorial' says that death was caused by a combination of factors and that factor 'X' was a more than minimal **contribution** to death (even if on its own it would not have caused death), if 'X' was caused by the act or omission of the defendant, we can show causation. This is so even if any one of the other factors would have been sufficient to have caused death on their own. This is an area that needs to be carefully analysed. What will not be sufficient to prove causation is a statement that, death was caused by any one or more of a number of causes and it cannot be said for sure that the relevant one was an operative cause, only that it might have been.

I hope that this is of assistance. I will be happy to discuss further if you wish but I shall be away on leave for a week from 16 August.

Yours sincerely

Robert Drybrough-Smith
Head of London Division II