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Shared Insights

Corporate and gross negligence manslaughter in the health and social care sector

Speakers

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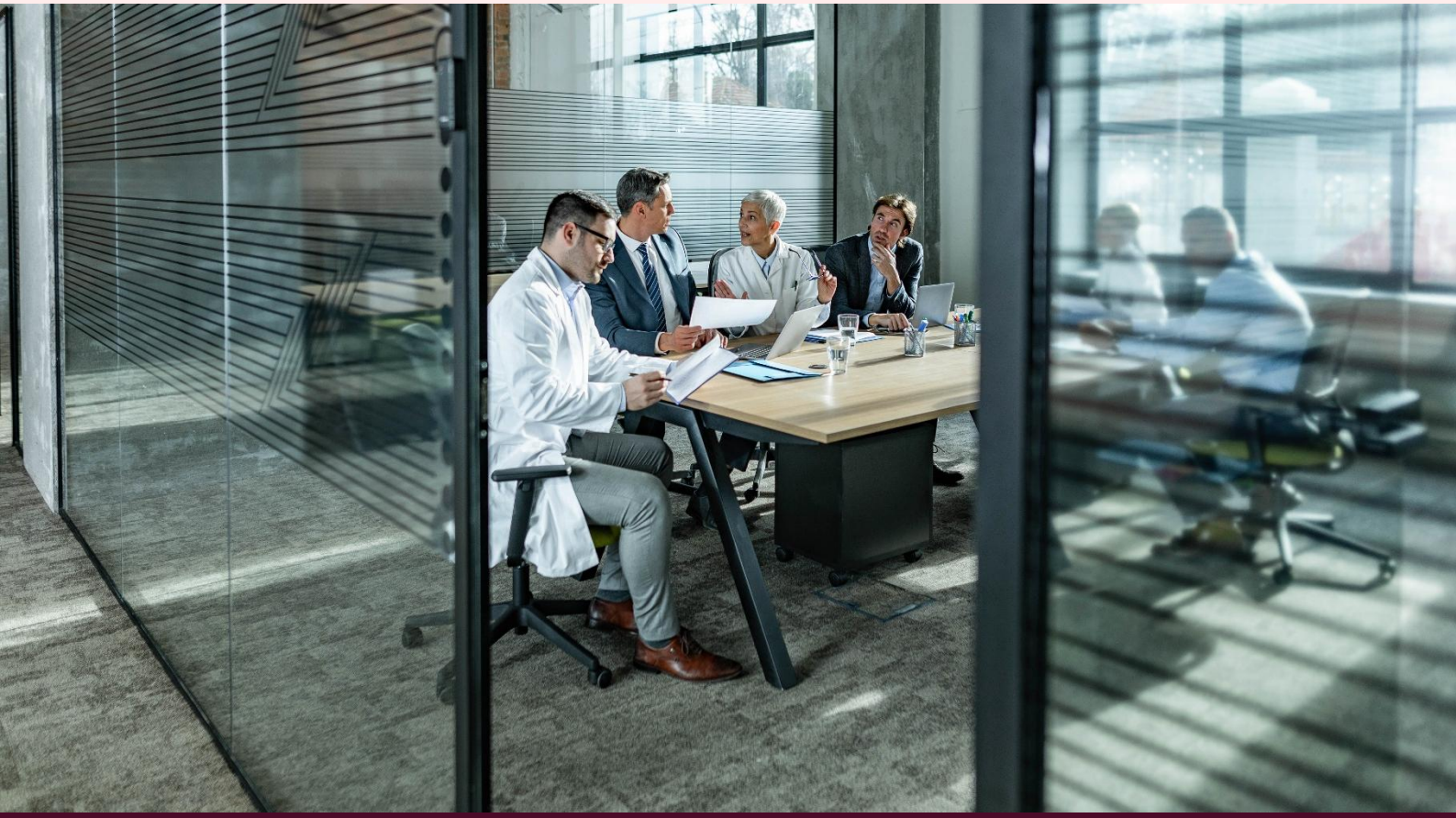
Paul Calaminus – CEO at North East London NHS Foundation Trust (NELFT)
Charlotte Harpin – Partner at Browne Jacobson
Mark Barnett – Partner at Browne Jacobson
Jacqui Atkinson – Partner and Head of Employment Healthcare at Browne Jacobson

NELFT NHS
NHS Foundation Trust



Browne Jacobson

Introduction

This session, chaired by Carl May-Smith, Partner and Barrister at Browne Jacobson, focussed on corporate and gross negligence manslaughter in the health and social care sector. We discussed the practical realities of facing such investigations and prosecutions, drawing on the first-hand experience of a senior NHS leader – Paul Calaminus, CEO of North East London NHS Foundation Trust (NELFT).

Whilst prosecutions for corporate and gross negligence manslaughter in health and social care remain relatively rare, the landscape is evolving and it is essential for provider organisations to understand the legal framework, the investigative process and the practical implications of such proceedings.

This session provided an opportunity to hear directly from those who have navigated these challenging circumstances. The discussion covered the legal definitions and requirements for both criminal offences, the critical importance of governance and expert support from the outset, meaningful family engagement, staff wellbeing and employment considerations, the interplay with inquests and regulatory inspections, and the vital role of risk management and corporate memory.

The insights shared offer valuable guidance for healthcare organisations seeking to prepare for and manage these complex, lengthy, and high-stakes processes whilst remaining true to their organisational values and commitment to transparency.

Contents

How we can help

We have a number of lawyers at Browne Jacobson who are experienced in corporate and gross negligence manslaughter proceedings and similar prosecutions, such as Health and Safety Executive and CQC prosecutions. Our expert regulatory team includes criminal lawyers specialising in the health and social care sector such as Carl May-Smith, who regularly defend and have previously prosecuted these offences. This gives us valuable insights and an enhanced ability to negotiate for clients involved in investigations and enforcement action.

Inquests often run parallel to corporate and gross negligence manslaughter prosecutions and we have a number of lawyers, including Mark Barnett and our team of in-house barristers, who can advise and represent health and social care organisations in coroners' courts across the country.

This includes complex and challenging inquests, such as those engaging Article 2 of the European Convention on Human Rights or sitting with a jury.

Public inquiries can also run alongside criminal prosecutions. Our pragmatic and highly experienced public inquiries team, led by Charlotte Harpin, has the capability and resources to support health and social care providers with both statutory and non-statutory inquiries. Charlotte and her team also regularly advise on complex governance and public law issues in the health sector.

Any regulatory or criminal action can lead to employment challenges and can significantly impact staff wellbeing. Our experienced Healthcare Employment team, led by Jacqui Atkinson, offers comprehensive legal support to senior leaders and managers, providing strategic advice and guidance on effective approaches.

Understanding corporate and gross negligence manslaughter

Carl May-Smith – Partner and Barrister,
Browne Jacobson

Corporate manslaughter

Corporate manslaughter is a criminal offence applicable to organisations or corporate bodies, such as NHS Trusts. Several elements need to be established for a prosecution to succeed.

- The organisation must owe a duty of care to the person who has died – this is likely to be satisfied in a health and social care setting.
- There must be a gross breach of that duty, which is so serious as to be criminal.
- The way activities are managed or organised within the organisation by senior management must be a substantial element of the breach. This usually involves senior managers at board level, but it can extend below board level depending on the nature of the organisation.
- The gross breach must have caused or contributed to the death, although it needn't be the sole cause.

The elements must be proved to the criminal standard, which is beyond all reasonable doubt.

Gross negligence manslaughter

Gross negligence manslaughter is a criminal charge faced by individuals. Again, certain elements need to be proved beyond all reasonable doubt.

- There must be a duty of care owed to the deceased.
- The breach of that duty must be gross – so bad as to be criminal.
- The breach must have caused or contributed to the death.
- A reasonably prudent person would have foreseen a serious and obvious risk of death.

Distinctive features of manslaughter prosecutions

Corporate and gross negligence manslaughter prosecutions differ significantly from CQC prosecutions in terms of duration, publicity, volume of work and penalties. Individuals convicted of gross negligence manslaughter can face prison sentences, while corporate manslaughter convictions can result in heavy fines. Manslaughter prosecutions in healthcare are however very rare. The prosecutions brought against NELFT featured unique elements, including the first prosecution at ward manager level, giving an indication of the changing landscape.

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Key actions at the initial stage

Charlotte Harpin – Partner, Browne Jacobson
Paul Calaminus – CEO at NELFT

Governance and expertise

Charlotte asked Paul Calaminus, CEO of NELFT, about the key actions that should be taken at the very initial stages of a prosecution. Paul explained that NELFT's case, which involved corporate manslaughter charges against the Trust and a gross negligence manslaughter charge against a ward manager, took ten years from start to finish. Trust personnel changed during this timeframe, with the exception of one person from the legal team, who was involved throughout.

The first consideration was who would be the Trust's point of contact, both internally and externally. NELFT appointed an expert to help with the investigation process, who saw the case through from the initial investigation stages to the court process and trial. This expert assistance was hugely important.

The expert appointed was a consultant psychiatrist. He prepared an initial opinion, which was shared with the police, and he remained as one of the defence experts.

Charlotte stressed the importance of carefully considering the required expertise, and recommended considering a project manager as well as a clinical expert. Workflow will fluctuate, between periods of high and low intensity, making it essential to maintain a well-defined workplan. She also addressed the challenge of preserving corporate memory over extended timeframes, particularly given personnel changes. She suggested that clear governance structures and robust project management support are effective strategies to mitigate this issue.

Communication and candour, including with families

When facing a manslaughter charge, Paul stressed the need to talk both internally and externally about the situation, without sharing sensitive details.

It's important to talk about the fact that the prosecution is happening, and not to shy away from that, otherwise it becomes an unspoken secret that everyone knows about.

Paul highlighted the importance of candour and communication with family members of the deceased, although he acknowledged that this is hard to get right at such a difficult time for a family. He underscored the responsibility of senior leaders within the organisation communicating with families, rather than delegating this task.

Preservation of documents

Charlotte noted the importance of preserving documents, and staff understanding the meaning and purpose of non-destruction orders.

Key takeaways on fundamentals

- Be clear on governance and think carefully about the expertise required. Project management is recommended.
- Being candid with staff and stakeholders is key.
- Engaging with the family at a senior level is crucial, but there are challenges with this and it can be difficult to get right.
- Preservation of documents is essential – ensure staff are aware of and understand non-destruction orders.

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Inquests and coroner involvement

Mark Barnett – Partner, Browne Jacobson
Paul Calaminus – CEO at NELFT

Mark explained a coroner can suspend an inquest under Rule 25 of the Coroners (Inquest) Rules 2013 and may do so in circumstances of a potential or ongoing criminal investigation. However, the coroner will be very conscious of how long criminal proceedings may take and won't want to leave the family in limbo. If criminal proceedings have arisen, the inquest could engage Article 2 of the European Convention on Human Rights. A jury may be required and there could be expert evidence. There will be reputational issues to consider as well as witness management.

Key witnesses involved in the incident itself will need to give evidence at the inquest, and they will need support. Open, transparent and clear communication throughout the process is essential. There may be conflicts of interest between the organisation and certain witnesses, in which case separate interested person status and legal representation may be required for those people. This needs to be identified as soon as possible and the coroner needs to be informed without delay.

Balancing organisational values with legal risks

Paul discussed organisational values and noted that, when going through inquests and criminal investigations, you find out whether those values are upheld in practice or not. Paul tried to keep in mind his organisation's values when navigating NELFT's complex investigations.

There are obviously organisational risks associated with inquests and other similar processes; however, inquests are ultimately for the bereaved family, so they can understand what happened and be assured that lessons have been learned. Organisations should be as honest as they can be about what happened and any action taken since. Inquests present several challenges for legal teams and governance staff, and there is a real worry about the potential impact of inquest findings on other investigations. However, you need to be true to who you are as an organisation. What do your organisational values say, and how do they come through? Organisations need to reflect on their stated values, particularly in difficult situations such as facing a corporate manslaughter charge.

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Employment and staff wellbeing

Jacqui Atkinson – Head of Healthcare Employment, Browne Jacobson
Paul Calaminus – CEO at NELFT

Supporting staff during investigations

Jacqui spoke from an employment and staff wellbeing perspective, having supported trusts facing manslaughter charges over a number of years.

Family engagement has changed significantly over the years and has become much more prevalent. The needs of the family need to be balanced against the needs of the workforce, however, and Jacqui asked Paul how NELFT navigated between keeping the two sides in play.

Paul said that NELFT did its best, but this is an area where there is often no right answer. He reflected on learning points, particularly regarding the significance given in the proceedings to job descriptions titles. Having 'manager' was seen to have affected the justice system's view of the ward manager role. In addition, the related job description contained the sentence '24-hour responsibility for the ward environment.' This responsibility proved difficult to clearly define to those in the justice system without medical experience, particularly in the context of the MDT and a framework of people with specific roles. The judge's sentencing remarks focussed on the job description and its importance.

In terms of staff, there is a whole set of dynamics – e.g. people who are going to be witnesses, people who might be interviewed by police who then become witnesses – and there are uncertainties around what you can say to them and what they can say to you. NELFT organised staff support from a neighbouring trust, working closely with police and the CPS regarding the tight boundaries for this.

Paul emphasised the importance of staff belonging to a union, who can offer support (including legal representation) during proceedings. He noted that some people do not join unions since membership costs money, but it has been a wake-up call as to how important it is to be in a union when things like this happen.

Managing witness support

Jacqui explained that, during the criminal process, everything comes under the glare of that spotlight. Supporting witnesses can easily look like you are coaching witnesses, so it's crucial to liaise very closely with CPS to check the parameters of what you're doing.

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Discussion

The evolving nature of manslaughter investigations

Carl emphasised that every manslaughter investigation is different, with different organisations, issues and individuals involved. Historically, prosecutions in a healthcare context have tended to focus on individual incidents and have been largely unsuccessful. However, Carl noted that corporate manslaughter investigations are now starting to look at a series of related incidents, or the overall work of a service or department where systemic problems may have been identified over a period of time. The nature of such investigations therefore appears to be evolving, although we haven't yet seen any prosecutions out of such investigations, which underscores how long the process takes.

Timeline and stop-start nature of proceedings

Paul reiterated that the whole process took a very long time and was "stop-start" in nature. There were periods where nothing happened, followed by periods of intense activity – even once the trial started. For the whole time, the proceedings were hanging over people and weighing heavily on them, so it's important to keep talking to and supporting them.

Concurrent regulatory scrutiny

Paul noted that Trusts under investigation will attract more scrutiny from the CQC. In the middle of the trial, NELFT had a well-led inspection, which resulted in additional scrutiny, data requirements and pressure. It was very stressful with both the trial and the inspection happening at once.

The Trust also had to continue to meet NHS England targets and budget requirements.

Unexpected developments

Paul explained that the investigation and prosecution was very detailed (over 29,000 pages of evidence), and many unexpected things arose. At court, there was a dispute and lack of clarity over the cause of death – this issue still wasn't clear at the end of the judge's sentencing. Even with all the information and data gathered, and the length and depth of the investigation, there were still unexpected incidents along the way. Paul echoed Charlotte's recommendation of a project manager.

Different perspectives on risk

Paul noted judicial perspectives on ward safety measures can sometimes prioritise the prevention of harm over considerations of patient autonomy. For example, there may be an expectation of implementing blanket restrictions, such as keeping certain doors permanently locked, even if this impacts all individuals on a mental health ward. This approach reflects a view that the benefits of reducing risk outweigh the drawbacks of imposing general restrictions, although such measures are not typically favoured by providers or the CQC, who place greater emphasis promoting a therapeutic environment and minimising blanket restrictions

Carl noted that non-CQC inspectors or prosecutors don't necessarily appreciate things that healthcare professionals take for granted, such as balancing risks. The police, the Crown Prosecution Service, judges and others in the criminal justice system are not necessarily familiar with working in a healthcare environment and sometimes find it difficult to accept that patients should be allowed to take risks. It's important to make these issues clear from the outset, otherwise you could end up with judicial decisions at odds with normal practice in a healthcare setting.

Carl highlighted that there is a Memorandum of Understanding (MoU) between healthcare organisations, regulatory bodies, investigatory bodies and prosecutorial bodies in England, which sets out how these organisations will work together in cases where there is suspected criminal activity in the provision of clinical care or care decision-making. Charlotte noted that the MoU includes references to "just culture", however this is now termed as "being fair" by the NHS. Further, the MoU was updated following the 2018 Williams report into gross negligent manslaughter in healthcare. One of the key recommendations was that the MoU should provide for better engagement with affected families, which resonates with Paul's reflections.

From an employment perspective, when thinking about just culture or being fair, it's important to ensure the patient perspective, and not just the staff perspective, is factored into decision making. What can seem just for staff does not always feel just for patients/families.

Internal learning response v external processes

Paul was asked how NELFT's internal learning response fitted with the external processes. Paul explained that the Trust conducted a Serious Incident (SI) investigation. He reflected on the need to involve the family in these investigations to a greater degree than often occurs. He stressed the need for the investigation process to delve into the full detail of what happened from the family's perspective. (Under the Patient Safety Incident Response Framework, there is now much greater emphasis on involving families in patient safety investigations.)

Reflective notes and professional development

Carl addressed concerns about clinicians' reflective notes being used in the context of these investigations. There was real concern at one point in time about whether reflective notes could be used in prosecutions, following the 2018 prosecution of Dr Hadiza Bawa-Garba. However, the CPS and police have said that only in truly exceptional circumstances will reflective notes be used. The GMC and NMC have also confirmed that they will not seek to use or rely on reflective notes in their investigations.

There are worries that clinicians and management will stop writing reflective notes because of concerns surrounding their potential use, so it's important to provide reassurance. It would only be in a very extreme case that reflective notes would come into play.

Risk management and governance – identifying and managing emerging risks

Charlotte explained it's important to make the time to think about the risks that are emerging, how they are identified, mitigated and managed. With new models of care and working, especially collaboratively, there is often not an early focus on potential risk, and how that is going to be recorded, managed and who is responsible. It is important to take a little bit of time to pause and assess what is important in terms of risks.

Documentation and data management

Carl noted organisations are producing more and more data, so there is now an expectation from CQC that it's possible to demonstrate quality assurance. The regulator is asking for more and more detail about risks and how they are managed. Providers are hoping that technology will soon be able to assist with this, as there is some exciting technology out there that may be able to help pull this information together as and when needed in the future. One of the current big challenges is finding the right information in an efficient way. CQC, in particular, generally takes the approach that if it cannot be demonstrated, it didn't happen.

Charlotte advised to make sure systems are easy to navigate, because it will be much simpler to respond to an investigation if the information is easy to find. Carl also stressed the importance of preserving institutional memory, and ensuring that when people leave an organisation, their information is retained and still accessible.

Jacqui noted that in some employment tribunal processes recently, where assurance with regard to documentation and management was needed, the use of e-resourcing was helpful. E-resourcing is an expensive resource but helpful in these processes as it aids with corporate memory.

Key takeaways

- Corporate manslaughter is a charge against organisations whereas gross negligence manslaughter is a charge against individuals. In both cases, there must be a gross breach of a duty of care, which is so serious as to be criminal, and the breach must have caused or contributed to the death.
- Prosecutions in healthcare are very rare, but the nature of investigations is changing, with some now looking at systemic problems over longer time periods rather than single incidents.
- Clear governance is essential from the outset, including appointing an expert to assist with the investigation, identifying a senior point of contact, and ensuring robust project management to maintain corporate memory throughout what can be a very lengthy process.
- Internal communication and candour are vital, as is meaningful engagement with the family of the deceased from a senior level.
- Job descriptions should be carefully drafted with consideration of how they might be interpreted in legal proceedings. The importance of union membership for all staff cannot be overstated, as unions can provide crucial legal support.
- Investigations and prosecutions take a very long time with stop-start periods of activity. There is no leeway from regulatory requirements during this time.
- Judges and prosecutors from outside the healthcare context may not understand the balancing of risks that is routine in healthcare settings, making it important to explain these concepts clearly from the outset.
- Getting the internal investigation process right at the beginning, with the right authors and full engagement with the family, is vital as it can set the course for years to come.
- Reflective notes will not be used in prosecutions unless there are exceptional circumstances, and clinicians and managers should be reassured to continue engaging in reflective practice.
- Risk management requires time to pause and assess emerging risks, robust documentation that can be easily accessed, and systems to preserve corporate memory when individuals leave the organisation.

Resources

Our website provides several free inquest resources, including several useful guides on the inquest process:

- Guide to coroners' inquest process for witnesses.
- Guide for clinical witnesses writing coroner's inquest statements.
- Guide to inquests for mental health patients.
- Inquests and Article 2 of the European Convention of Human Rights.
- Guide to preparing and delivering a prevention of future deaths report.
- You can access these and other resources via our dedicated inquest web page.

Memorandum of Understanding: Investigating healthcare incidents where suspected criminal activity may have contributed to death or serious life-changing harm

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