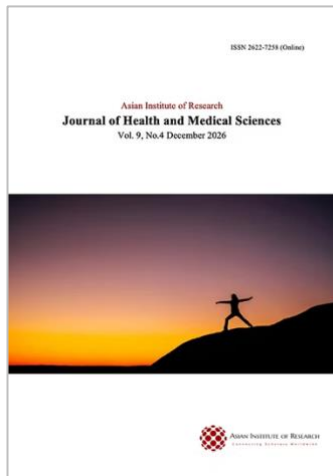




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Reforming the Law on Gross Negligence Manslaughter in Healthcare within England and Wales: A Post-Pandemic Evaluation of the Williams and Hamilton Paradigm

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Abstract

There is a deep structural crisis at the intersection of clinical medicine and criminal law in England and Wales. This paper attacks the use of the common law principle of gross negligence manslaughter (GNM) in response to involuntary clinical error and argues that the existing legal framework is driven by an unprincipled regimen of single agency fault. This approach compresses complicated, multi-factorial institutional failures into the sole criminal liability of the practitioner on duty, equating an unfortunate consequence with the blameworthy. Using a dual-axis framework that integrates doctrinal legal analysis with socio-technical systems theory and human factors engineering, this paper analyzes the institutional processes leading to and shaping key judicial decisions and considers the actual nature of health care. This study concludes that current legal approaches do not advance patient safety, and, post-pandemic, contribute to an unacknowledged, destructive diffuse risk for health professionals, ultimately inducing systematic defensive medicine, which in turn creates new safety hazards and fundamentally undermines patient-practitioner interaction. While the principle of a "just culture" has been called for in the context of administrative review, this aspirational goal is systemically undermining by the retributive rules of the criminal justice system. This paper concludes with concrete legal reform suggestions; to both codify a statutory framework and to adopt a subjective recklessness standard, ensuring criminal law responds only to criminal intent and to systemic institutional factors that the system's penal framework fails to address.

Keywords: Gross Negligence Manslaughter, Medical Errors, Defensive Medicine, Subjective Recklessness, Socio-Technical Systems

1. Introduction

The fusion of crime and regulation into medical law, presents an intensely constitutional and doctrinal puzzle within the law of England and Wales. To begin, the purpose of tort law is compensation for the victims of medical negligence, but by the operation of the criminal law by the offence of Gross Negligence Manslaughter, a penalty, the objective of which is the punishment of exceptionally egregious criminal misbehavior, has been grafted onto the operation of the medical profession resulting in an intense structural issue. In and through the multiple agents

and institutional complexity of modern tertiary health contexts, clinical treatment is rarely discrete, solitary and removed from the outside world; rather it is delivered in an intensely stressful environment and the physician's conduct is inevitably shaped by the structures and processes of her context.

The breadth of risk involved in the clinical arena makes the tenuous nature of this legal interface clear. Even in its initial statements regarding medical errors as criminal, authorities warned that while the probability of dying in a commercial aircraft crash is one in ten million, the probability of dying in the event of a medical error is one in 300 (Alghrani et al. 2023). Current estimations of the frequency of iatrogenic events or patient safety-related risks consistently remain around 12% in all settings globally (Alghrani et al. 2023). However, even in a context where safety is mandated universally across health agencies, the criminal justice system has been slow to embrace and, to this day, only rarely incorporates a focus on systemic problems rather than singling out a single practitioner to answer for a single event (Alghrani et al. 2023).

On a constitutional level this punishment undermines the essential characteristic of rule of law which requires predictability (Bingham, 2011). Certainty implies that criminal responsibility can only exist where it is rooted in certain objective and predictable criteria so that individuals can predict the consequences of their conduct (Bingham, 2011). In relation to GNM, certainty was rendered obsolete by the leading common-law test from *R v Adomako*,¹ which gave the jury discretion to decide whether conduct was 'gross', through a retroactive exercise. Critics of the law have always found the fatal circularity; behavior is only treated as criminal because the jury finds that it is, not because it broke an independently legislated rule (Quick, 2006; Quick, 2010).

This incoherence in the law was exacerbated by the Court of Appeal's decision in *R v Rose*,² which cemented a five-stage test, the result of which required the prosecution to prove beyond reasonable doubt that the defendant's breach of duty caused "an obvious and serious risk of death". The decision in *R v Rose*, was lauded by some as the definitive gatekeeper preventing malicious or vexatious prosecutions, however, it equally raised the issue of what some lawyers call the loophole of "negligent ignorance" (Mullock, 2018). In terms of this, where a clinician deliberately fails to undertake a necessary test, they could fall outside the net of criminal law on the grounds that by reason of their failure to do the necessary, the risk of death to the patient at the time was not subjectively appreciated by them (Mullock, 2018).

The intense friction between the two spheres culminated following the high-profile conviction of junior paediatrician Dr Hadiza Bawa-Garba.³ This was an event that laid bare how 77 institutional and systemic faults can be "driven down" in pursuit of a single point of failure. Driven by "toxic fear" within the NHS, and a corresponding wave of defensive practice, government set up two pivotal policy inquiries: the Williams Review (2018)⁴ and the Hamilton Review (2019).⁵ Both inquiry reports recommended de-criminalisation, proposing the "just culture" where clinicians can admit to errors and organizational learning occur, without fear of over-punishment.

However, the effects of these remedial frameworks must be considered within a broader context. In medical cases of error where criminal liability is applied, an immense amount of psychological strain is placed on clinicians (Gharaibeh, 2022). Although clinical strain did exist before, it has now been drastically amplified post-pandemic. It is apparent from recent qualitative data that displays the breakdown of systems, that litigation now acts as a generalized diffused sense rather than a "real threat of litigation" for clinicians (Lorenc et al., 2024). This causes a cycle of detrimental processes, including defensive documentation and a protocol-centric method, to arise from this fear of litigation, thereby undermining clinical humanism and the valuable time doctors spend with their patients. Failure in the medical field can be attributed to numerous factors, including those stemming from humans, systems, and disease (Roman et al., 2022). Traditional methods of analysis based on engineering approaches, such

¹ *R v Adomako* [1995] 1 AC 171.

² *R v Rose* [2017] EWCA Crim 1168; [2018] QB 328.

³ *Bawa-Garba v General Medical Council* [2018] EWCA Civ 1879.

⁴ Sir Norman Williams, Gross Negligence Manslaughter in Healthcare: The Independent Review (Department of Health and Social Care, 2018).

⁵ Leslie Hamilton, Independent Review of Gross Negligence Manslaughter and Culpable Homicide (General Medical Council, 2019)

as classical RCA, fail because they assume linear interactions when, in reality, there are nonlinear interactions (Jalali, 2025).

The article attempts to examine the survival of the Williams and Hamilton paradigm in post-pandemic England and Wales and also demonstrate how the current case law directions continue to maintain an unprincipled preference for harm over subjective culpability (Lodge, 2017). The article suggests and pulls together a fully-formed law reform model by arguing that an adequate provision of patient safety and the establishment of an adequate clinical culture can only be achieved through reforms in policy and the enactment of a new statute aimed at completely codifying medical manslaughter and the establishment of subjective recklessness as the required standard (Stark, 2019) in order to guard honest clinical errors.

2. Theoretical Background

In order to examine critically the structural infirmity of the practice, and the system wide ramifications of the prosecution of doctors for gross negligence manslaughter, it is important initially to contextualize the offence within criminal philosophy broadly construed. The invocation of the coercive penal power of the state post a patient's demise cannot be grounded in the magnitude of the evil which has been generated; it must be rooted in settled jurisprudential concepts that proscribe the moral permissibility of the coercive force of criminal sanctions. To that end, the following section lays the necessary doctrinal foundations, and analyzes the normative frictions which underscore the criminality of medicine, by deconstructing the marriage of ordinary criminal standards of criminal culpability and the intrinsically pro-social orientation of medicine by means of the following three interacting and reciprocal analytic frameworks: The basic strictures of the harm principle; the systemic aberrations attendant the criminalization of medical practice; and, the reciprocal interdependencies within multi-agency socio-technical systems.

2.1. *The Limits of Criminalization and the Harm Principle*

The expansion of criminal and corporate liability into the clinical arena demands robust theoretical justification based on general criminalization principles. It is at the heart of the structure of modern penal theory that state coercive criminalization must be constrained by principled structural thresholds. One principle which forms the bedrock of this whole discussion is the 'harm principle,' suggesting that the 'basic justifying ground of coercive intervention against the person is the prevention of wrongful harm to others'(Feinberg, 1987; Mill, 2008). Here in this discussion concerning medical manslaughter, whilst the objective outcome of death undeniably represents the gravest harm of the highest order, the theoretical rationale of criminalising the activity which brought this about is intensely problematic.

Theoretical analysis of criminal wrongfulness has indicated that merely producing a bad outcome is not enough to ground criminal liability. The offending behavior also requires a commensurate degree of moral blameworthiness (Feinberg, 1987; Simester et al., 2016). In ordinary criminal law doctrine this blameworthiness has been based upon subjective mens rea states, such as intention or recklessness. This means that the wrongdoer chooses to bring about the harm or takes an unjustified risk of harm in full awareness that this might happen (Brudner, 2008). Negligence, on the other hand (even with a qualification of 'gross') depends upon a failure to meet the reasonable man standard; the defendant is held responsible not for what they foresaw, but for what they ought to have foreseen (Hall, 1963; Hart, 1968). What this appears to mean in relation to clinical professionals, however, is that there exists a severe conceptual disconnect. The very purpose of medical intervention is altruistic - to heal the sick and to save the vulnerable (Duff, 2018). It therefore becomes an uncertain paradigm, challenging the principles of penal law, when an unintended clinical mistake arising from an immense web of interwoven factors is to be considered criminal (Husak, 2009).

2.2. *Overcriminalization and the Phenomenon of Pervasive Retribution*

The process whereby medical professionals are singled out and pursued through the framework of common law gross negligence manslaughter could be described as 'overcriminalisation'. It has been argued by legal scholars

that the expansion of penal statutes and criminal liability 'beyond the appropriate boundary of criminal regulation' is a continuing risk to the justice system, particularly when such issues could 'be better regulated through the civil law, administrative procedures or professional disciplines' (Husak, 2009). Overcriminalisation is understood as the application of criminal law as 'a coarse tool of social regulation', whereby 'the outer boundaries of the penal law [are] blurred' and the 'expressive value of criminal conviction...is diluted' (Husak, 2009). By condoning the criminalisation of acts devoid of any true moral culpability or intent, the judiciary undermines the inner consistency and moral coherence of the criminal justice system (Wilson, 2011; Wilson, 2017).

This expansive approach is driven by an impetus in both society and the judiciary for retribution, in the wake of tragic clinical incidents. The retributive form of justice argues that the culpability-based nature of criminal law demands punishment because a wrong has occurred which requires rectification through retribution, to 'restore the moral balance which the crime has destroyed' (Oldenquist, 1988). In relation to involuntary manslaughter in the context of medicine, however, this retribution can be seen as failing to distinguish between the seriousness of the event (the loss of human life) and the culpability of the clinician (Lodge, 2017), resulting in an "unprincipled privileging of outcome over culpability" where criminalisation focuses on achieving singular blame (Lodge, 2017). It removes the clinician from the wider institutional framework in which the act took place, providing public appeasement but obscuring the systemic origins of the error which the human error is merely the symptom of (Reason, 1990; Dekker, 2016).

2.3. Responsibility, Accountability, and the Relational Realm of Crime

In order to understand fully the distortion criminalization of clinical errors entails, we must first consider both criminal responsibility in general and institutional nature of the crime. Criminal responsibility is not a simple calculation of actus reus and mens rea, but a formal call by the political community to someone to answer for a public wrong (Duff, 2018). Within a communicative account of punishment, the individual is called to account for violation of public civil norms that the individual could fairly avoid (Marshall & Duff, 1998). Typical criminal wrongs, such as an assault or an omission in the classic criminal context, clearly demonstrate the relational and individualistic nature of the offense (Herring, 2015).

In the context of modern public healthcare systems, a death resulting from medical error cannot simply be a case of a lone, independent failure (Oikonomou et al., 2019). Clinical practice is inextricably linked to highly institutionalized, dynamic interactions in resource allocation, staffing, hierarchy, and design. By forcing a single clinician to account for systemic failings, the criminal law demands an extremely harsh type of responsibility unsuited for the multi-actor environment of contemporary healthcare (Quick, 2006). The criminal system requires treating a systemic, non-linear failure as an individual, linear moral offense, and fails to recognize that true accountability in safe systems must be restitutionary and organizational rather than punitive and retributive (Dekker, 2016). This mismatch creates a pervasive systemic tension in which an institution designed to enforce public safety fosters fear and endangers long-term patient care (Gharaibeh, 2022).

3. Research Methodology

In order to mount a meaningful, legally defensible critique of the criminalization of clinical negligence in the post-pandemic context, the present paper makes use of a multi-layered methodological approach. Assessing the judicial efficacy of GNM is not something that can be done solely through an ex post factum legal examination. Rather, it involves an examination that requires an interrogation and reconciliation of black-letter law and the real-life working, socio-technical systems within the practice of medicine. It is the purpose of this section to explain the dual-axis methodology which governs this paper: the specification of the scope of the doctrinal legal research design which will be used to analyze primary and secondary legal materials, and the socio-technical systems perspective with which the multifaceted systemic and multifactorial nature of clinical failure will be critically assessed.

3.1. Doctrinal Legal Research Design

This paper's chief research matrix is qualitative doctrinal legal research, a widely accepted approach to jurisprudential and institutional analysis (Duncan and Hutchinson, 2012). Doctrinaire research may be broadly defined as "the methodical, analytical exposition of legal principles, rules and doctrines based on close consideration of legal sources" (Duncan and Hutchinson, 2012). As such, it is an investigative approach that moves beyond the descriptive identification of existing laws. Instead, it engages with the law's internal coherence and validity, demonstrating inconsistencies, structural flaws and the impact of particular judicial rulings (Duncan and Hutchinson, 2012).

In this paper, the doctrinal matrix is utilized in analyzing the development of involuntary manslaughter in the specific jurisdiction of England and Wales. The primary source materials are subject to qualitative interpretation and include appellate court decisions, statutes and official prosecutorial guidelines. Specifically, several judgments of the House of Lords and the Court of Appeal-including *R v Adomako*⁶, *R v Rose*,⁷ and *R v Bawa-Garba*⁸ are examined in order to demonstrate how the threshold of "serious and obvious risk of death" has shifted. These data, which represent primary legal authority, are supplemented by formal legal sources of authority in secondary form, including reports of the Law Commission, textbooks on criminal law (such as Simester and Sullivan's Criminal Law Theory and Doctrine and Smith & Hogan's Essentials of Criminal Law) and published legal journal articles. The systematic textual analysis highlights the doctrinal conflict between objectifying standards of conduct and establishing individual culpability.

3.2. Socio-Technical and Systemic Review Framework

The doctrinal method allows us to analyze the law itself but fails to address how the law acts as a driver in the complex operational environment. In order to overcome these limitations, this study combines a doctrinal legal approach with the theory of socio-technical systems and human factors engineering paradigms. Human factors engineering describes an approach focusing on how humans and other components interact within a system, utilizing theories and data for the purposes of enhancing human well-being and overall system performance (Jalali, 2025).

The insertion of human factors engineering into legal analysis therefore, establishes a specific methodology to question how the system functions in the case of fatal medical errors. The systemic model is used specifically as a way to attack the investigative mechanisms such as traditional RCA utilized by both medical institutions and legal experts. The typical RCA mechanism presupposes that there must be a linear cause behind a system's failures: a singular human failure or a defectively designed system component (Jalali, 2025). In contrast, this study utilizes a non-linear, socio-technical approach that argues failure is an emergent property of the complex system (Reason, 1990; Dekker, 2016).

In order to enact a systemic attack on this model, the research incorporates a qualitative review of detailed clinical case studies and post-pandemic qualitative data. A qualitative comparison of the multivariable factors causing medical errors reveal how the interaction of human failure, a system failure on the institutional level, and the severity of a patient's condition are conducive to creating a catastrophic outcome (Roman et al., 2022). As such, the methodology proceeds as a systematic attack that uses doctrinal legal research to reveal the individualistic bias of the law, and human factors engineering to illuminate how that bias fails to analyze and assess the realities of the multiagency environment that exists in modern medicine.

4. Legal Controversies and Policy Implications

The use of gross negligence manslaughter (GNM) in the clinical context has proved profoundly unstable doctrinally and has contributed to the breakdown of trust between the medical and judicial professions. Instead of serving as a coherent, consistent deterrent as an extension of public responsibility, the common law prosecution of GNM is in constant conflict with contemporary medical policy and infrastructure. The following segment

⁶ *R v Adomako* [1995] 1 AC 171.

⁷ *R v Rose* [2017] EWCA Crim 1168; [2018] QB 328.

⁸ *Bawa-Garba v General Medical Council* [2018] EWCA Civ 1879.

critically examines the legal and policy disjunctions between the two. It begins with an overview of the chaotic path of judicial interpretation of GNM, with reference to appellate authority, proceeds to an examination of empirical evidence of defensive practice fueled by fear of criminal charges in the post-pandemic setting, and finishes with an analysis of the policy dissonance between recent government reviews and the penal guidelines of the criminal justice system.

4.1. *The judicial trajectory of gross negligence manslaughter*

The modern framework for clinical GNM in England and Wales is anchored in a common-law architecture that critics argue lacks the precision required by the rule of law. The modern test was established by the House of Lords in *R v Adomako*,⁹ which formulated a four-stage test: the existence of a duty of care, a breach of that duty causing death, and a determination by the jury that the breach was sufficiently 'gross' to be categorized as criminal. Legal scholars have persistently attacked the *Adomako* framework for its inherent circularity (Quick, 2006; Quick, 2010). By transferring the task of defining the threshold of criminality to a lay jury, the law creates an *ex-post facto* determination where conduct is labeled criminal simply because the jury chooses to criminalize it, rather than because it breached a clear statutory boundary (Quick, 2006; Spencer, 2008).

This circularity was further complicated by the Court of Appeal in *R v Rose*,¹⁰ which attempted to restrict arbitrary prosecutions by adding an objective gatekeeper mechanism. The court ruled that the prosecution must prove that, at the time of the breach, it was reasonably foreseeable to a reasonable clinician that the breach posed a "serious and obvious risk of death". While *R v Rose* successfully overturned the conviction of an optometrist and raised the bar for prosecution, it created a dangerous doctrinal loophole described as "negligent ignorance" (Mullock, 2018). Under the *Rose* doctrine, if a clinician completely fails to perform a basic diagnostic examination, they can avoid criminal liability because their very failure prevents them from subjectively or objectively appreciating the immediate risk of death (Mullock, 2018). This rewards systemic or individual ignorance, privileging the unobservant clinician over one who conducts a partial assessment but misinterprets the findings (Mullock, 2018). The structural crisis reached its peak with the prosecution of Dr. Hadiza Bawa-Garba,¹¹ which illustrated the legal system's tendency to prioritize individual blame over systemic accountability. In this case, a junior pediatrician was convicted of GNM following a series of errors during a shift characterized by acute institutional failure, including a total failure of the hospital's IT infrastructure, severe understaffing, and a complete absence of consultant supervision. The criminal process largely ignored these environmental variables, focusing instead on isolating a single human agent to bear strict accountability for a multi-agency system failure (Alghrani et al., 2023). This approach demonstrates a persistent flaw in the common law, where the justice system privileges the severity of the outcome (the patient's death) over the actual moral culpability of the clinician, who was operating within a collapsed institutional infrastructure (Lodge, 2017).

4.2. *Defensive medicine and the post-pandemic diffuse sense of risk*

The practical consequence of this doctrinal instability is the widespread institutionalization of defensive medicine across the National Health Service (NHS). Historically, defensive healthcare practices—defined as the deviation from sound medical practice primarily to avoid litigation or criminal prosecution—were viewed as a direct response to a specific, identifiable threat of a lawsuit or a criminal investigation (Lorenc et al., 2024). However, qualitative data from the post-pandemic era demonstrate that this dynamic has evolved into a much more pervasive and systemic institutional reality (Lorenc et al., 2024).

Clinicians now operate under a generalized and "diffuse sense of risk" rather than a calculated fear of legal action (Lorenc et al., 2024). The disruptions caused by the COVID-19 pandemic—including permanent staffing shortages, unmanageable patient backlogs, and compromised operational resources—have left medical practitioners feeling permanently exposed to systemic failures that they cannot control (Gharaibeh, 2022; Lorenc et al., 2024). To protect themselves against potential criminal scrutiny under the loose *Adomako* standard,

⁹ *R v Adomako* [1995] 1 AC 171.

¹⁰ *R v Rose* [2017] EWCA Crim 1168; [2018] QB 328.

¹¹ *Bawa-Garba v General Medical Council* [2018] EWCA Civ 1879.

clinicians engage in extensive "assurance behavior". This manifests as defensive over-documentation, where vast amounts of clinical time are redirected toward defensive record-keeping to provide a paper trail for future legal defense, rather than enhancing actual patient care (Lorenc et al., 2024). This defensive anxiety leads to over-testing, unnecessary specialist referrals, and a rigid, mechanical adherence to institutional protocols (Lorenc et al., 2024). Paradoxically, this behavior undermines patient safety by consuming finite clinical hours, overloading diagnostic pipelines, and eroding the empathetic, open clinician-patient relationship necessary for accurate diagnosis and error reporting (Gharaibeh, 2022; Lorenc et al., 2024).

4.3. Policy inquiries and the institutional push for a just culture

Recognizing that the threat of criminal prosecution was driving medical errors underground and crippling clinical morale, the UK government commissioned two major independent policy reviews. The first, the Williams Review (2018),¹² was specifically tasked with evaluating the application of GNM within healthcare settings. The review concluded that the current deployment of criminal law was generating an environment of toxic fear that actively undermined patient safety by discouraging clinicians from openly disclosing errors. Sir Norman Williams explicitly recommended that the bar for criminal prosecution must be raised significantly, suggesting that GNM should be reserved exclusively for cases involving clear, flagrant disregard for patient safety, and that the expert witness selection process must be strictly reformed to ensure appropriate clinical context is integrated into judicial proceedings.

This policy direction was reinforced by the Hamilton Review (2019),¹³ commissioned by the General Medical Council (GMC). The Hamilton Review emphasized the urgent need to establish a "just culture" within the NHS, defining it as an environment where healthcare professionals are trusted and actively encouraged to report mistakes, but where a clear line is drawn between honest human error and truly egregious, reckless conduct. The review explicitly argued that treating systemic, multi-agency clinical failures as individual criminal acts prevents institutional learning, leaving the underlying systemic vulnerabilities unaddressed and exposing future patients to identical risks (Alghrani et al., 2023).

However, a profound disconnect remains between these administrative policy goals and the formal guidelines that drive the criminal justice system. While the Williams and Hamilton reviews called for a de-escalation of punitive measures to protect the reporting of errors, the Sentencing Council for England and Wales simultaneously published its *Manslaughter Definitive Guideline*.¹⁴ This guideline established a highly punitive framework for GNM, creating a structured sentencing matrix that significantly increased the baseline custodial terms for individuals convicted of gross negligence manslaughter. By emphasizing deterrence and retribution, these sentencing guidelines directly conflict with the administrative push for a just culture (Alghrani et al., 2023). The criminal justice system continues to operate on the individualistic assumption that severe prison sentences will deter negligence, completely ignoring the socio-technical reality that clinical errors are produced by system complexities that cannot be resolved through individual deterrence (Jalali, 2025; Reason, 1990).

5. Single Agency Culpability and Clinical Human Error

The architecture of criminal prosecutions in healthcare environments relies on a flawed conceptual reductionism, wherein complex institutional failures are compressed into the singular legal personhood of the attending clinician. By invoking the blunt mechanisms of the criminal law, the judiciary enforces a restrictive framework of single-agency culpability that effectively decouples a fatal medical outcome from the socio-technical matrix in which it occurred. This individualized focus creates a judicial blind spot, forcing a monolithic narrative of personal blameworthiness upon a reality that is inherently collective, fluid, and structurally constrained. In practice, the success rate within clinical medicine can never realistically achieve absolute certainty; rather, medical failure is dictated by a highly complex, multi-factorial convergence of structural deficiencies, human fallibility, and the

¹² Sir Norman Williams, Gross Negligence Manslaughter in Healthcare: The Independent Review (Department of Health and Social Care, 2018).

¹³ Leslie Hamilton, Independent Review of Gross Negligence Manslaughter and Culpable Homicide (General Medical Council, 2019).

¹⁴ Sentencing Council, Manslaughter Definitive Guideline (Published 31 July 2018, Effective 1 November 2018)

baseline clinical severity of the patient's condition (Roman et al., 2022). By insisting on isolating a human culprit, the criminal court privileges retributive satisfaction over systemic investigation, treating the symptomatic expression of error as its primary moving cause (Reason, 1990; Dekker, 2016).

5.1. The illusion of autonomy in complex hospital environments

The foundational error of the criminal process lies in its insistence on treating the medical practitioner as a wholly autonomous operative, entirely insulated from organizational pressures and cognitive constraints. Modern clinical delivery, particularly within high-stress tertiary and emergency departments, requires clinicians to operate under continuous structural strain, where overbooked lists, acute understaffing, and sudden clinical deteriorations test human capacities to their absolute limits (Jalali, 2025; Roman et al., 2022). To expect flawless cognitive performance within an environment characterized by fallible instrumentation, fragmented communication, and systemic friction is an operational impossibility (Dekker, 2016). Under these strained conditions, treating a technical error or a cognitive lapse as an index of criminal recklessness or gross negligence imposes an unconscionable burden upon the medical profession (Samanta and Samanta, 2019).¹⁵

When legal frameworks apply a linear test of causality to an adverse medical event, they fundamentally misunderstand the nature of unsafe environments. Human factors engineering demonstrates that errors do not occur in a vacuum; they emerge from non-linear, unpredictable interactions among tightly interconnected system variables, including poorly designed interfaces, institutional culture, and administrative constraints (Jalali, 2025). When the state leverages the criminal justice apparatus to target an individual doctor following a tragedy, it perpetuates a systemic injustice. It ignores the reality that these practitioners are frequently forced to navigate unsafe clinical systems without an institutional safety harness, rendering the subsequent conviction an exercise in organizational scapegoating rather than genuine public protection (Reason, 1990; Dekker, 2016).

5.2. Empirical realities of failure and patient outcomes

To reconstruct a legal framework that genuinely prioritizes patient safety, the law must move away from the traditional search for criminal culprits and embrace an open, non-punitive learning environment. Empirical analysis of adverse medical events underscores that even when healthcare providers adhere strictly to clinical pathways and execute their professional duties with maximum fidelity, tragic outcomes can still transpire due to systemic limitations or the volatile severity of an acute disease (Roman et al., 2022). The sudden convergence of institutional vulnerabilities, such as the absence of permanent vascular surgery lines or delayed diagnostic tools, can destabilize an otherwise sound clinical intervention, turning a survivable trauma into a fatal casualty (Roman et al., 2022).

The intrusion of criminal sanctions into this delicate operational balance carries severe socio-legal consequences. When clinicians observe their peers being subjected to public prosecution and long custodial sentences for honest, systemic errors, they experience a profound psychological trauma that destroys professional trust (Gharaibeh, 2022; Samanta and Samanta, 2019). This pervasive anxiety shifts clinical behavior from open error-reporting to defensive non-disclosure, effectively driving critical safety data underground (Ferner and McDowell, 2006; Roman et al., 2022). An organization can only learn and build a resilient safety culture when it possesses the psychological safety to analyze both large and small failures transparently, without the hovering threat of criminal retribution (Jalali, 2025; Roman et al., 2022). Ultimately, the public interest is disserved by a punitive legal doctrine that insists on punishing the individual clinician; true systemic resilience demands a restorative paradigm that focuses on optimizing the processes, technologies, and institutional structures that support human work at the bedside (Reason, 1990; Dekker, 2016).

¹⁵ The systemic degradation of clinical autonomy and its intersection with criminal liability was acutely illustrated during the appellate review of institutional failures in *Bawa-Garba v General Medical Council* [2018] EWCA Civ 1879

6. Law Reform Model

To address the profound doctrinal inconsistencies of the common-law framework and the resulting culture of fear within the medical community, a fundamental legislative restructuring is required. Administrative policy interventions and shifting internal guidelines are structurally insufficient to remedy an offense that inherently privileges tragic outcomes over actual moral culpability. This section details a comprehensive, principled model for statutory reform within England and Wales. It advocates for the complete abolition of common-law gross negligence manslaughter in clinical settings and details a statutory solution centered on the subjective recklessness paradigm, thereby ensuring that criminal sanctions are reserved strictly for morally blameworthy behavior while shielding honest clinical errors from unjust criminalization.

6.1. Codification and the statutory dismantling of common-law gross negligence

The historical reliance on ad-hoc common-law developments to determine the criminal liability of healthcare professionals creates an unpredictable legal landscape that directly breaches the foundational principles of statutory legality and legal certainty (Bingham, 2011). The drafting of criminal justice frameworks must not be impenetrable, nor should it leave the fundamental definitions of criminality to the shifting, retrospective perceptions of a lay jury (Spencer, 2008). Consequently, the current common-law offense of gross negligence manslaughter must be formally dismantled and replaced by a clear, codified homicide architecture as repeatedly recommended in previous law reform evaluations (Law Commission, 1994; Law Commission, 2006).¹⁶

A codified approach ensures that the boundaries of penal liability are explicitly and prospectively defined by parliament prior to judicial enforcement, satisfying the constitutional demand for accessible and foreseeable laws (Bingham, 2011). By replacing the circular *Adomako* test with an explicit statutory framework, the legislature can articulate a precise threshold of criminal liability, effectively removing the judicial ambiguity that has historically driven defensive medical practice and institutional panic within the healthcare sector (Spencer, 2019).

6.2. The subjective recklessness paradigm as a statutory solution

The core of this legislative reform model lies in replacing the objective standard of negligence with a strict subjective fault requirement. Under a reconstructed statutory framework, criminal liability for medical manslaughter should be restricted exclusively to cases where the prosecution can prove subjective recklessness (Stark, 2019). Incorporating a subjective standard means that a clinician can only be convicted if they consciously foresaw a serious and obvious risk of death and unjustifiably chose to disregard it, ensuring that the target of penal law is an unconscionable choice rather than an inadvertent cognitive failure or a skill-based error (Stark, 2019). This threshold aligns with broader criminal law doctrines which dictate that penal sanctions must track actual subjective culpability rather than the gravity of inadvertent harm (Brudner, 2008).

Furthermore, comparative assessments demonstrate that other European jurisdictions successfully separate pure clinical negligence from criminal homicide, relying instead on strict disciplinary and administrative regulatory frameworks to maintain public safety without destabilizing clinical morale (Spencer, 2010). By confining criminal intervention to subjective recklessness, the law successfully balances safety and accountability, establishing a true just culture where honest, multi-factorial errors are addressed via organizational learning, while flagrant, conscious misconduct is met with legitimate penal sanctions (Dekker, 2016; Stark, 2019).

7. Conclusion

The intersection of criminal law and medical practice within England and Wales has reached a critical juncture that demands immediate legislative intervention. This study has demonstrated that the historical reliance on common-law gross negligence manslaughter fails to accommodate the socio-technical complexities of modern

¹⁶ The structural necessity for a comprehensive statutory overhaul was formally delineated in the draft Criminal Code Bill frameworks; see Law Commission, Involuntary Manslaughter (Law Com No 135, 1994) and Law Commission, Murder, Manslaughter and Infanticide (Law Com No 304, 2006).

healthcare systems, resulting in an unprincipled regime that privileges tragic outcomes over subjective moral culpability (Lodge, 2017; Quick, 2006). The current judicial paradigm, destabilized by the structural circularity of the Adomako test and the doctrinal loopholes of the Rose directive, imposes a form of single-agency culpability that systematically converts multi-factorial institutional failures into individual criminal wrongs (Mullock, 2018; Roman et al., 2022).

The empirical evidence from the post-pandemic landscape reveals that this punitive framework does not enhance patient safety; instead, it fosters a pervasive, toxic culture of fear and a diffuse sense of risk that drives destructive defensive medical practices and undermines open error reporting (Gharaibeh, 2022; Lorenc et al., 2024). While administrative inquiries like the Williams and Hamilton reviews have advocated for the cultivation of a "just culture," their policy objectives are actively neutralized by the punitive reality of current sentencing frameworks (Alghrani et al., 2023). True systemic resilience and the protection of clinical practice cannot be achieved through administrative adjustments alone.

Ultimately, this article has argued for a definitive law reform model centered on the statutory codification of medical homicide and the implementation of a subjective recklessness standard (Stark, 2019). By requiring the prosecution to prove conscious risk-taking, the law can effectively shield honest, system-induced clinical errors from unjust criminalization while reserving penal sanctions for genuinely egregious misconduct (Dekker, 2016; Stark, 2019). Moving from a retributive model of individual blame to a restorative model of systemic optimization is not merely a doctrinal necessity; it is an ethical imperative to preserve the sustainability of healthcare delivery and the integrity of the criminal justice system (Jalali, 2025; Reason, 1990).

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