

**THE ROLE OF THE CRIMINAL LAW AND THE  
CRIMINAL PROCESS IN HEALTHCARE MALPRACTICE  
IN FRANCE AND ENGLAND**

**A thesis submitted to the University of Manchester for the  
degree of Doctor of Philosophy in the Faculty of Humanities.**

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**The Role of the Criminal Law and the Criminal Process in Healthcare Malpractice**  
**in France and England**  
**2013**

This thesis seeks to contribute to the debate about the role of the criminal law in holding health professionals and health institutions to account for malpractice. The research attempts a critical comparison of the role of the criminal law and the criminal process in healthcare malpractice in France, a civil law jurisdiction, and England, a common law jurisdiction. In France, the criminal process is more readily invoked to address failings and malpractice in healthcare. The aim of this research is to see how the comparison of the two jurisdictions sheds light on the now much debated question of how the criminal process should relate to healthcare malpractice. The purpose of the comparative examination of law and process is twofold: (1) to highlight what might be seen as failings within each legal system and identify lessons that might be learned from each other and (2) to locate these differences in an analysis of how (if at all) the criminal process can best engage with healthcare malpractice. The much publicised HIV-contaminated blood episode in France and England is studied as an illustration of a case of systemic healthcare failure and the use of the criminal process in France. It is used to illustrate and explore more fully the questions above and shed light on the overall aim of the thesis, which is to assess what the role of the criminal law should be in the context of healthcare malpractice.

The research reveals that particular features of the general substantive criminal law and criminal process go a long way toward explaining differences in the criminalisation of healthcare malpractice as between France and England. The criminalisation of ‘simple’ direct negligence which may result in death or injury in France provides the possibility to criminalise healthcare malpractice more readily than in England, where only gross negligence resulting in death is generally criminalised in the healthcare malpractice context. Features of the French inquisitorial criminal process (notably *juges d’instruction* and *parties civiles*) play a central role in providing a greater platform for the criminalisation of healthcare malpractice in France, whereas features of the English adversarial system (in particular the role of the Crown Prosecution Service and the jury) tend to minimise the possibility for a wider criminalisation of healthcare malpractice in England.

However, I do not argue that England should follow France in adopting more extensive use of the criminal process in the context of healthcare malpractice. Key lessons drawn from the present study are that the criminal process is not usually an appropriate means to respond to many instances of healthcare malpractice. This is not to say that the criminal process has no role to play where the conduct of the professional has shown no regard for the safety of patients. Features of French criminal law and criminal procedure might be useful to counteract healthcare malpractice using alternative non-criminal proceedings. For instance, it will be argued that the model of thorough investigations conducted by *juges d’instruction* in the French criminal process could be better achieved outside the criminal law to provide transparency in the healthcare context. The study will point out the limitations of the criminal process in preserving health and safety and will thus highlight the importance of alternatives to the criminal process such as prevention in the healthcare setting and support to victims of healthcare malpractice.

## **DECLARATION**

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

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## LIST OF ABBREVIATIONS

AFH	Association française des hémophiles (French Haemophiliacs' Association)
AHRC	Arts and Humanities Research Council
AIDS	Acquired Immune Deficiency Syndrome
BMJ	British Medical Journal
BPL	Blood Products Laboratory
BTSAC	Blood Transfusion Service Advisory Committee
CCG	Clinical Commissioning Group
CCTS	Commission consultative de la transfusion sanguine (Advisory Committee on Blood Transfusion in France)
CDC	Center for Disease Control, Atlanta, Georgia, USA
CJR	Cour de justice de la République (Court of Justice of the Republic in France)
CMCH 2007	Corporate Manslaughter and Corporate Homicide Act 2007
CNH	Comité national de l'hémophilie (National Haemophilia Committee in France)
CNTS	Centre national de transfusion sanguine (National Blood Transfusion Centre in France)
CP	Code pénal (French Criminal Code)
CPA 1987	Consumer Protection Act 1987
CPP	Code de procédure pénale (French Code of Criminal Procedure)
CPS	Crown Prosecution Service
CQC	Care Quality Commission
CTS	Centre de transfusion sanguine (Blood Transfusion Centre in France)
DGS	Direction Générale de la Santé (Direction General of Health in France)
DH	Department of Health
DHSS	Department of Health and Social Security
DP	Diagnostics-Pasteur
FC	Factor concentrates

FVIII	Factor VIII Concentrate
FIX	Factor IX Concentrate
GBH	Grievous Bodily Harm
GMC	General Medical Council
GNM	Gross Negligence Manslaughter
HCJ	Haute cour de justice (High Court of Justice in France)
HGH	Human Growth Hormone
HIV	Human Immunodeficiency Virus
HSE	Health and Safety Executive
HSWA 1974	Health and Safety at Work Act 1987
HTLV-III	Human T-Lymphotropic Virus-Type III
INSERM	Institut National de la Santé et de la Recherche Médicale (National Institute of Health and Medical Research in France)
JI	Juge d’instruction (Investigating judge in France)
LAV	Lymphadenopathy Associated Virus
LNS	Laboratoire national de la santé (National Health Laboratory in France)
MMWR	Mortality and Morbidity Weekly Report
MP	Ministère Public (Prosecution Service in France)
MPTS	Medical Practitioners Tribunal Service
NBTS	National Blood Transfusion Service
NHS	National Health Service
NHSLA	NHS Litigation Authority
OAPA 1861	Offences Against the Person Act 1861
ONIAM	Office national d’indemnisation des accidents médicaux (National Office for the Compensation of Medical Accidents in France)
PCT	Primary Care Trust
PIP	Poly Implant Prothèse
PM	Prime Minister
PWH	People with Haemophilia

RHA	Regional Health Authority
SCCTD	Special Crime and Counter Terrorism Division
vCJD	variant Creutzfeldt-Jakob Disease
UKHCDO	United Kingdom Haemophilia Centre Directors' Organisation
WHO	World Health Organisation

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To all the victims of the HIV-contaminated blood episode in France and England and their family. I hope this PhD will help to learn from errors made in the past and to prevent future healthcare disasters.

## 1. Introduction

### The Criminal Process and Healthcare

Any activity involves a certain level of risk. As in any other activity, mishaps occur in the delivery of healthcare.<sup>1</sup> In this thesis, I do not address obviously blameworthy wrongdoing which aims to hurt others.<sup>2</sup> I address healthcare malpractice in the context of failure to provide the level of safe care expected from healthcare services and individual professionals. The causes of failure may be diverse and include mistakes that reasonable and competent practitioners make in the course of their practice. Sometimes failure may be the result of behaviour which reveals a more culpable frame of mind and disregard to the life of others. Negligent behaviour in everyday life can have serious consequences depending on the type of activity involved. Negligence in the healthcare context more particularly may lead to tragic consequences including injury, life-threatening injury or death. Paradoxically, an activity which aims to heal may instead harm or kill. The victims of this type of mishaps, or their family, consequently ask for reparation and justice, and sometimes seek to attribute blame onto someone. This may result in the recourse to legal proceedings.<sup>3</sup> Such legal proceedings may take several forms. They may involve disciplinary proceedings against responsible professionals or claims for compensation for the harm caused, or criminal proceedings. This thesis focuses on the use of criminal proceedings in the healthcare malpractice context.

The relationship between criminal law and healthcare malpractice<sup>4</sup> has not always been as fully debated as it has come to be in the latter part of the 20<sup>th</sup> century and the start of

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<sup>1</sup> For example, in England, between 60000 and 255000 patients per year in NHS services suffer serious disability or death resulting from healthcare intervention; Department of Health, *An Organisation with a Memory: Report of an Expert Group on Learning from Adverse Events in the NHS chaired by the Chief Medical Officer* (London: HMSO 2000) 11; A Merry, A McCall Smith, *Errors, Medicine and the Law* (Cambridge University Press 2001) 1.

<sup>2</sup> In this thesis, I am concerned with healthcare malpractice in the sense of error and disregard to the life of others, but not intentional wrongdoings as was the case in the Shipman scandal in England, where Doctor Shipman was sentenced to life imprisonment for the murder of numerous patients; see <<http://webarchive.nationalarchives.gov.uk/20090808154959/http://www.the-shipman-inquiry.org.uk/backgroundinfo.asp>>; Unknown author, 'Shipman jailed for 15 murders', *BBC News*, 31 January 2000.

<sup>3</sup> A Merry, A McCall Smith, above n1 at 1.

<sup>4</sup> The term 'healthcare malpractice' will be used in the whole of the thesis as a general term for negligent conduct which occurs in the healthcare setting.

the 21st.<sup>5</sup> In England in 2006, a claim was made that there was an unjustified rise of criminal prosecutions against medical practitioners for ‘medical’ manslaughter.<sup>6</sup> The study was based on a search in newspapers from 1795 to 2005. The results of this study suggested that the threshold to prosecute doctors for GNM was perhaps low. A study conducted by Sanders and Griffiths analysing 75 prosecution case files on ‘medical’ manslaughter showed however that the Crown Prosecution Service (CPS) demonstrated rather a reluctance to prosecute doctors.<sup>7</sup> The ensuing debate highlighted the question of how and why the criminal process should be used to hold healthcare practitioners and institutions to account for poor practice. The question is the subject of debates outside England, notably in countries known for using the criminal law more readily to deal with healthcare malpractice. In France, much publicity has been given<sup>8</sup> to criminal proceedings arising out of the HIV-contaminated blood episode which was said to show that there is a greater desire to use the criminal law in France in the context of healthcare malpractice.<sup>9</sup> New Zealand, a common law country, used to endorse criminalising ‘simple’ negligent conduct as France still does. This led to a campaign conducted by Merry<sup>10</sup> against the use of the criminal law for ‘simple’ negligence in New Zealand where a person is now only criminally liable for ‘neglecting a legal duty’ if the neglect was a ‘major departure from the standard of care expected of a reasonable person to whom that legal duty applies or who performs that unlawful act’.<sup>11</sup> This debate over the role of the criminal law in healthcare malpractice has led to studies comparing the use of the criminal law in England and New Zealand to assess whether lessons could be learnt in England from looking at how healthcare malpractice used to be criminalised in New Zealand, and how it is now after the reforms which limited the use of the criminal process

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<sup>5</sup> There is a rapidly developing body of literature now addressing this question. A good starting place for considering the literature on this is: C Erin, S Ost (eds), *The Criminal Justice System and Health Care* (Oxford University Press 2007).

<sup>6</sup> RE Ferner, SE McDowell, ‘Doctors charged with manslaughter in the course of medical practice, 1795-2005: a literature review’ (2006) 99 *Journal of the Royal Society of Medicine* 309.

<sup>7</sup> D Griffiths, A Sanders, ‘The Road to the Dock: Prosecution Decision-Making in Medical Manslaughter Cases’, in D Griffiths and A Sanders (eds), *Medicine, Crime and Society* (Cambridge University Press Forthcoming 2013) 117.

<sup>8</sup> D Marchetti, ‘La genèse médiatique du "scandale du sang contaminé"' in *Ethique, sida et société*. Rapport d'activité du Conseil national du sida (La Documentation Française, Janvier 1993).

<sup>9</sup> AM Farrell, M Kazarian, ‘The Role of the Criminal Law in Healthcare Malpractice in France: Examining the HIV Blood Contamination Episode’, in D Griffiths and A Sanders (eds), *Medicine, Crime and Society* (Cambridge University Press Forthcoming 2013) 265-279.

<sup>10</sup> Alan Merry is Professor of Anaesthesiology at the University of Auckland, New Zealand. He was one of the campaigners in favour of raising the threshold for criminal negligence from simple to gross negligence which was contextualised by the Crimes Amendment Act 1997 in New Zealand. See A Merry, ‘When Are Errors a Crime?-Lessons from New Zealand’, in C Erin, S Ost (eds), *The Criminal Justice System and Health Care* (Oxford University Press 2007) 68.

<sup>11</sup> Crimes Act 1961 s 150A (b); A Merry, above n10 at 68.

in the area of negligence.<sup>12</sup> More particularly, drawing on the comparison with New Zealand, Merry and McCall Smith have examined the role of the law in healthcare malpractice more generally and have addressed what they see as the proper remit for the use of legal proceedings in healthcare malpractice. In particular, they have argued that in the case of errors, the law should not usually have a role.<sup>13</sup> They claimed that the use of legal proceedings against individuals would fail to identify systems error and could not deter conduct which does not involve moral culpability.<sup>14</sup> However, they argued that ‘violations’ defined as actions which show deliberate risk taking could be the subject of legal proceedings because they can be deterred and are morally culpable.<sup>15</sup>

In this thesis, it will be argued that a critical comparison of the role of the criminal law in healthcare malpractice in France and England grants support to the argument that the criminal process is not an appropriate means to respond to many instances of healthcare malpractice. This is not to say that the criminal process has no role to play where the conduct of the professional has shown no regard for the safety of patients. The analysis and comparison of the use of the criminal law in France and England is used to provide additional arguments for Merry and McCall Smith’s claim that the role of the criminal law should be limited and normally used to punish morally wrong conduct.

### **Origins of Thesis: Case Study within ‘The Impact of the Criminal Process on Health Care Ethics and Practice’ Project**

This thesis was written as part of a research project funded by the Arts and Humanities Research Council, ‘The Impact of the Criminal Process on Health Care Ethics and Practice’ (AH/E009816/1) and led by Professor Margaret Brazier. The project addressed the following questions:

- 1) ‘How effectively does and can the criminal justice system operate as a forum for resolving ethical conflict in the delivery of health care?’
- 2) ‘Are medical practitioners accorded a privileged status in proceedings relating to accountability for (mal)practice?’

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<sup>12</sup> A Merry, above n10 at 67-73; See for instance P Skegg, ‘A Fortunate Experiment?: New Zealand’s Experience With A Legislated Code of Patients’ Rights’ (2011) 19 *Medical Law Review* 235.

<sup>13</sup> A Merry, A McCall Smith, above n1 at 2.

<sup>14</sup> Ibid 101.

<sup>15</sup> Ibid.

My research related to the latter. As part of the latter question, themes investigated in the project were the extent of the deference historically attached to the medical profession and its impact on criminal prosecutions for healthcare (mal)practice, the extent and impact of the growing vulnerability of the medical profession to criminal liability and the impact of attitudes of patients and the public on criminal prosecutions of health professionals for negligent (mal)practice, particularly in terms of blame and retribution. With regards to analysing the impact of the criminal process on health care professionals and the extent to which the medical profession is vulnerable to criminal liability, the project also investigated (inter alia) the criminalisation of healthcare malpractice in New Zealand and Crown Prosecution Service (CPS) policy relating to prosecutions of doctors for gross negligence manslaughter (GNM) in England.<sup>16</sup>

Within the project and in agreement with the AHRC, two case studies were funded by the School of Law and undertaken by doctoral students working within the project and basing their theses on the case study they were engaged to research. The case studies were designed to help shed light on the very different ways that the criminal process engages with healthcare and explore how different jurisdictions approached broadly similar problems in very different ways. The case study linked to the research questions relating to the criminal process and healthcare ethics compared developments in England and the Netherlands regarding the engagement of the criminal law in the issue of ‘mercy killing’.<sup>17</sup>

It is the second case study that forms the origins of this thesis and for which I was funded as a project student. The case study was initially about the role of the criminal law in the HIV-contaminated blood episode in France but broadened to examining the role of the criminal law in healthcare malpractice more generally. Working with Dr Anne-Maree Farrell, I examined the use of the criminal process in France in the HIV-contaminated blood episode in the 1990s.<sup>18</sup> We sought to understand the extensive use of the criminal process in France compared to England where a similar blood contamination episode

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<sup>16</sup> D Griffiths, A Sanders, above n7.

<sup>17</sup> A Mullock, ‘End-of-life Law and Assisted Dying in the 21<sup>st</sup> Century: Time for Cautious Revolution?’ (Ph.D. thesis, University of Manchester 2011).

<sup>18</sup> Initially, the comparison was envisaged between the role of the criminal law in the HIV-contaminated blood episode in France and the retained organs episode in England but in the course of the project, it was decided that a comparison between the role of the criminal law in the HIV-contaminated blood episodes in both countries would be more fruitful.



happened at the same time and as I will establish, the moral culpability of health service officials is hard to distinguish. Yet in England the episode did not lead to prosecutions.<sup>19</sup>

Within the case study we considered earlier literature that sought to explain the different responses in terms of differences in culture and politics and we attempted to assess if other factors played a significant role and might so far be somewhat neglected in the literature. In particular, Farrell had earlier analysed the policy-making of French blood authorities in the HIV-contaminated blood episode and argued that the use of legal proceedings in the episode revealed the 'long-standing conflict between Parliament, the executive and the judiciary over control and legitimacy in national political life'.<sup>20</sup> Thus she found that the use of the criminal law in the episode in France was in part due to cultural, political and social factors.

The initial aim of the case study was limited to an examination of how and why the criminal process was used in France and not in England as a response to the episode.<sup>21</sup> When HIV<sup>22</sup> started to spread as an epidemic, most European countries including England and France were affected by HIV contamination of the blood supply resulting in thousands of victims in each country.<sup>23</sup> In England and France, it was said that authorities had not responded to the contamination early enough to stop it and as a consequence, victims sought to engage in legal proceedings. In France, the episode created a debate among media, politicians and the public, on whether or not civil servants and medical practitioners should be convicted of criminal offences for the contamination of blood products affecting thousands of people.<sup>24</sup> The case was brought to criminal courts and continued for 15 years and three sets of criminal proceedings.<sup>25</sup> Yet, overall, French victims remained unsatisfied by the outcome of the proceedings. In contrast, even though the rates of HIV infection as between people with Haemophilia (PWH) in France and England were similar and comparable steps were taken in relation to dealing with the risk posed by HIV to the respective national blood supplies, in England, only one abortive and

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<sup>19</sup> A search of all the literature and media found only one criminal investigation conducted by the CPS in England which did not lead to a prosecution. This investigation is further discussed in later chapters. See D Black, 'Police drop 'bad blood' scandal', *The Journal* (Newcastle, 7 July 2003).

<sup>20</sup> AM Farrell, 'Contaminated Blood, A Comparative Study of Policy-Making Arising out of HIV Contamination of the Blood Supply in France, the United Kingdom and Ireland' (Ph.D. thesis, University of Manchester 2004) 113.

<sup>21</sup> AM Farrell, M Kazarian, above n 9.

<sup>22</sup> Human Immunodeficiency Virus (HIV) is the virus responsible for Acquired Immune Deficiency Syndrome (AIDS).

<sup>23</sup> J Ruffié, JC Sournia, *La transfusion sanguine* (Fayard 1996) 309.

<sup>24</sup> O Beaud, *Le sang contaminé, Essai critique sur la responsabilité des gouvernants* (Presses Universitaires de France 1999) 3-6.

<sup>25</sup> AM Farrell, M Kazarian, above n9 at 265.

minor investigation was undertaken and no prosecutions followed. Victims had to rely on ex gratia payments, civil proceedings<sup>26</sup> and an independent inquiry which was conducted by Lord Archer of Sandwell some twenty years after the episode.<sup>27</sup> English victims were also unsatisfied with the response given by the Government. This thesis draws on the study but has broader objectives as analysing the way in which the episode had been dealt with in France and England revealed that fundamental differences in substantive criminal law and process were integral to any understanding of the responses to the blood episodes and that France and England have, at least until recently, taken different views of the role of the criminal process in accountability for healthcare malpractice at the level of the individual clinician, the hospital and the health service nationally. Thus, the comparison of these different responses permits an exploration of the much larger issue of the proper role of the criminal law in the healthcare malpractice context.

The use of the criminal law in the HIV-contaminated blood episode became the subject of a book chapter co-written with Dr Anne-Maree Farrell, which is to be published in Danielle Griffiths' and Andrew Sanders' edited collection *Medicine, Crime and Society*.<sup>28</sup>

## 1.1 Objectives of Research

This thesis aims to analyse and assess the role of the criminal process in healthcare malpractice, drawing on an examination of how and why in France, the criminal process is more readily used to deal with healthcare malpractice than in England. I shall indicate that the resort to the criminal process in the 'scandal' of the HIV blood contamination episodes reflects the evidence that the criminal process plays a much larger role in France than in England in cases of healthcare malpractice. However, the thesis will note that in recent years, there seems to have been a partial withdrawal from the criminal law in the context of negligence generally and thus healthcare malpractice in France. The *Loi Fauchon* of 10 July 2000 limited the criminalisation of simple negligence to conduct that *directly* caused the damage and the *Loi du 4 mars 2002* created a no-fault compensation scheme for victims of serious medical accidents.<sup>29</sup> Nevertheless, there is no reliable

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<sup>26</sup> *HIV Haemophiliacs Litigation* [1990] 41 BMLR 171.

<sup>27</sup> Mr Justice Horace Krever, *Commission of Inquiry on the Blood System in Canada* (Final Report Vol 3, 1997) 940-942; [1990] 41 BMLR 171; Rt Hon Lord Archer of Sandwell QC, *Independent Public Inquiry Report on NHS Supplied Contaminated Blood and Blood Products* (23 February 2009).

<sup>28</sup> AM Farrell, M Kazarian, above n9.

<sup>29</sup> Loi n° 2000-647 du 10 juillet 2000, tendant à préciser la définition des délits non intentionnels (1) (JO 11 juill. 2000) 10484 ; Loi n° 2002-303 du 4 mars 2002 relative aux droits des malades et à la qualité du système de santé; S Taylor, 'Providing Redress for Medical Accidents in France : Conflicting Aims,

evidence yet as to whether these reforms have resulted in a decrease of criminal prosecutions for negligent behaviour, and consequently charges against negligent healthcare professionals and officials.<sup>30</sup> Understanding the reasons why the criminal law was invoked in France and not in England is used as an opportunity to contribute to the ongoing debate about how far the criminal process should relate to healthcare malpractice.

Any such study must note the more general question of the relationship between the criminal law and negligence, in particular between the law and healthcare negligence addressed by leading commentators who represent very different stances on the role of the criminal law in negligence. Opposite views are represented by Andrew Ashworth at one end and Alan Merry and Alexander McCall Smith at the other.<sup>31</sup> Put simply the debate is this: should the criminal process play any role in the context of injury caused by negligence? Ashworth argues that ‘crimes of negligence may exert a general deterrent effect, by alerting people to their duties and to the need to take special care in certain situations’. Thus, he argues for ‘negligence as a standard of liability for certain serious offences against the person’.<sup>32</sup> Merry and McCall Smith seem to disagree as they claim that errors cannot be deterred, but ‘violations’ can be deterred and therefore should be subject to criminal liability.<sup>33</sup> Brazier et al argue that only ‘disregard for the life of others should merit punishment’.<sup>34</sup> Quick argues that ‘there is no clear or strong case for additional specific offences beneath the level of recklessness, and that there is a need to consider ‘forms of organizational liability’.<sup>35</sup>

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Effective Solutions ?’ (2011) 2(1) *Journal of European Tort Law* 57, 61; S Taylor, ‘Clinical Negligence Reform : Lessons From France ?’ (2003) 52 *International and Comparative Law Quarterly* 737.

<sup>30</sup> S Taylor, ‘Providing Redress for Medical Accidents in France : Conflicting Aims, Effective Solutions ?’, above n29 at 61.

<sup>31</sup> These authors were chosen because they represent two opposing views of criminalisation in that area. Ashworth advocates the criminalisation of the types of conduct which are criminalised in France whereas Merry and McCall Smith defend a more restrictive use of the criminal law in the area of negligence. A Merry, A McCall Smith, above n1; A Ashworth, *Principles of Criminal Law* (6<sup>th</sup> edn, Oxford University Press 2009) 185-189.

<sup>32</sup> A Ashworth, above n31 at 188.

<sup>33</sup> A Merry, A McCall Smith, above n1 at 2-3.

<sup>34</sup> M Brazier, N Allen, ‘Criminalizing Medical Malpractice’, in C Erin, S Ost (eds), *The Criminal Justice System and Health Care* (Oxford University Press 2007) 27; M Kazarian, D Griffiths, M Brazier, ‘Criminal Responsibility for Medical Malpractice in France’ (2011) 27(4) *Journal of Professional Negligence* 188, 199.

<sup>35</sup> O Quick, ‘Medicines, mistakes and manslaughter : a criminal combination ?’ (2010) 69(1) *Cambridge Law Journal* 186, 199-201; O Quick, ‘Medical Killing: Need for a Specific Offence?’, in CMV Clarkson, S Cunningham (eds), *Criminal Liability for Non-Aggressive Death* (Ashgate 2008) 175; O Quick, ‘Medical Manslaughter: The Rise (And Replacement) of a Contested Crime?’, in C Erin, S Ost (eds), *The Criminal Justice System and Health Care* (Oxford University Press 2007) 47.

In my thesis, I shall demonstrate that the reasons for the wider criminalisation of healthcare malpractice in France as opposed to England are key differences in both substantive criminal law and criminal procedure. I will for this purpose critically compare the role of French and English substantive criminal law and criminal procedure in the context of healthcare malpractice and see how the comparison sheds light on my attempt to assess how the criminal process should relate to healthcare malpractice.

I shall identify several factors responsible for the wider use of the criminal law in France in the context of healthcare malpractice. It will be clear that they in part result from the fact that France takes a different approach to using the criminal law in the context of negligence much more broadly. I will critically compare the way in which negligent conduct is criminalised in France and England and as a consequence, the way in which healthcare malpractice is criminalised in both countries. I will look at the type of misconduct criminalised and the range of offences available to criminalise this type of conduct in the healthcare context in France and England. I will demonstrate that in France, for example, the criminal law (the law in books) includes a wider range of offences to penalise negligent conduct resulting in different levels of harm and thus suggests that the criminal law in France requires lower levels of moral culpability than in England. Also, features of French criminal procedure tend to make the criminal process more accessible in the context of healthcare malpractice and provide for a greater platform for the prosecution of medical professionals or officials for negligence. I also examine the role of the criminal law in individual malpractice as well as corporate malpractice and failures of senior officials in the healthcare context. The blood episode in particular will be used as an example of the criminalisation of healthcare malpractice at the level of public institutions.

The purpose of the comparative examination of law and process is twofold: (1) to highlight what might be seen as failings within each legal system and identify lessons that might be learned and (2) to locate these differences in an analysis of how the criminal process can best engage with healthcare malpractice. The general aims of English and French criminal law are much the same: to punish the offender by focusing on deterrence, incapacitation, retribution, rehabilitation and restoration.<sup>36</sup> Criminal law also aims to protect the victim and the society from antisocial conduct and to protect the offender from himself and from others, for instance the victims or their relatives who seek

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<sup>36</sup> CMV Clarkson, HM Keating and SR Cunningham, *Criminal law* (7<sup>th</sup> edn, Thompson Sweet and Maxwell 2010) 23-55; P Poncela, *Droit de la peine* (2<sup>e</sup> edn, Presses Universitaires de France 2001) 59-73; M Cusson, *La criminologie* (5<sup>e</sup> edn, Hachette 2011) 128-133.

restorative justice.<sup>37</sup> In the words of Ashworth, ‘the chief concern of the criminal law is to prohibit behaviour that represents a serious wrong against an individual or against some fundamental social value or institution’.<sup>38</sup> One question that is much debated in England and New Zealand and is a central question in my thesis is whether any conduct short of recklessness should engage the criminal law.<sup>39</sup>

In both countries, a criminal prosecution aims to protect the society as a whole.<sup>40</sup> The criminal law, as opposed to the civil law, is applied to preserve public interest.<sup>41</sup> Unlike criminal trials, civil trials do not aim to punish an offender but primarily seek to resolve a dispute and provide compensation for any harm allegedly committed. There are though a number of ways in which tort plays a role in deterrence and accountability.<sup>42</sup> However, the outcomes of French criminal proceedings are, if successful, the punishment of the wrongdoing and wrongdoer, justice, deterrence, retribution, restoration, incapacitation and as will be explained financial compensation to the victim(s), who have joined civil claims for compensation to a criminal complaint.<sup>43</sup>

The French view criminal law as perhaps the best way of restoring social order and protecting society from antisocial behaviour and wrongdoing, as well as fulfilling the need of victims for retribution and compensation.<sup>44</sup> Consequently, in France, in the context of healthcare malpractice, criminal law seems to be considered as a regulatory tool and an instrument to claim for justice and compensation, one amongst other instruments ie civil and administrative claims.<sup>45</sup>

This thesis will consider the question of whether the criminal law does and should play a role in ensuring retribution to victims. French criminal law is said to be a ‘system based on the notion that, where anything bad has happened, somebody must be singled out for public blame and punishment; a bonanza for the criminal law bar and a joy for the editors of tabloid newspapers, but for the proponents of a civilised criminal justice system, a

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<sup>37</sup> D Lanham, BF Bartal, RG Evans, ‘The Purposes of Criminal Law’, in D Lanham, BF Bartal, RG Evans, D Wood (eds), *Criminal Laws in Australia* (The Federation Press 2006) 1-9.

<sup>38</sup> A Ashworth, above n31 at 1.

<sup>39</sup> A Merry, A McCall Smith, above n1 at 2-3; M Brazier, N Allen, above n34 at 27; M Kazarian, D Griffiths, M Brazier, above n34 at 199.

<sup>40</sup> A Ashworth, above n31 at 1; ML Rassat, *Droit pénal général* (2<sup>e</sup> edn, Ellipses 2006) 98.

<sup>41</sup> A Ashworth, above n31 at 2; B Boulloc, *Procédure Pénale* (Daloz 2010) 3.

<sup>42</sup> J Murphy, *Street on Torts* (12<sup>th</sup> edn, Oxford University Press 2007) 17-18; This question is largely beyond the scope of this thesis.

<sup>43</sup> A Demichel, ‘Le droit pénal en marche arrière’ (1995) 28e cahier-chronique *Recueil Dalloz Sirey*, 213-216.

<sup>44</sup> V Wester-Ouisse, ‘Dépénalisation du droit médical’ (2008) Hors Série juillet *Revue générale de droit médical* 245; V Turcey, ‘Le point de vue du magistrat’, in D Dreyfuss, F Lemaire and H Outin (eds), *La judiciarisation de la médecine* (Médecine-Sciences Flammarion 2004) 4.

<sup>45</sup> V Turcey, above n44 at 3.

cause of misery and depression'.<sup>46</sup> This is especially true when the result of a doctor's negligence was the death or injury of a person: 'when the consequence of [his] fault has been the deprivation of a person's life, the conscience of the public demands reparation'.<sup>47</sup> As will be shown in Chapter 2, negligence offences in France were in part created to protect public interest as well as the bodily integrity of persons.<sup>48</sup>

So I will seek to show that substantive criminal law is one of the main factors which impact on the way healthcare malpractice is criminalised in France. I will demonstrate that the way in which the French legal tradition defines the criminalisation of negligence means that it has a broader scope than the common law in England. This is because it includes the penalisation of simple negligence and negligence resulting in injury. In contrast, only gross negligence resulting in death is usually criminalised in the context of healthcare malpractice in England. Given that general role assigned to the criminal process in France, arguments that healthcare practitioners and officials should be treated differently and protected to some extent against criminal proceedings become harder. However, as mentioned earlier, it will be noted that there has been a move away from the criminalisation of negligence and healthcare malpractice in France (see above).

The other significant factor explaining the wider criminalisation of healthcare malpractice in France is criminal procedure which has as much, if not greater, impact than substantive factors on how healthcare malpractice is criminalised in both countries. Thus, the thesis aims to identify procedural factors responsible for the greater use of the criminal law in the context of healthcare malpractice in France. I shall establish that differences in process and practice play a major role in determining how the letter of the law is applied to healthcare practitioners and officials. The French criminal process is based on an inquisitorial system whereas the English process is based on an adversarial system. Given this, I shall argue that the French procedural approach to the criminal process has an impact on how it is used in the context of healthcare malpractice. Thus, I will identify the most influential factors in the French criminal process which seem to explain why criminal law has a wider use in dealing with healthcare malpractice in France and helps on assessment of what the proper role of the criminal law should be in healthcare malpractice.

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<sup>46</sup> JR Spencer, MA Brajeux, 'Criminal liability for negligence-A lesson from across the Channel?' (2010) 59 *International and Comparative Law Quarterly* 18.

<sup>47</sup> A Chauveau, F Hélie, *Théorie du Code Pénal* (Marchal et Billard 1887) para 1407.

<sup>48</sup> See ch2 pt2.2, 40.

The most prominent differences between the French inquisitorial system and the English adversarial system are that a greater emphasis is put on pre-trial investigations in the French system. Thorough investigations are conducted by a single *juge d'instruction* (investigating judge) who has wide coercive powers of investigation. The greater significance of the *Intérêt Général* in the French system is demonstrated by the presence of the *Ministère Public* (Public prosecution service) who represents the interest of society. The fact that the criminal process in France is used as another means to respond to victims' demands for compensation, retribution and justice is evidenced by a greater involvement of victims in the criminal process, who have the right to launch criminal prosecutions by joining *constitutions de parties civiles* (civil claims for compensation) in criminal courts. On the other side of the channel, no *juges d'instruction* or *parties civiles* are involved in criminal proceedings. Criminal investigations are conducted by the police with the help of the CPS, which (as we shall see) is rather reluctant to prosecute health professionals for GNM. Victims do not have ready access to criminal proceedings and cannot claim for compensation in criminal courts. The presence of the jury in criminal trials involving health professionals charged with GNM is also a difference. French criminal proceedings for negligence offences do not include juries. I will argue that this has an impact on the way healthcare malpractice is criminalised<sup>49</sup>, given the fact that juries are said to be reluctant to convict doctors. These differences may go a long way explaining the greater use of the criminal law in the context of healthcare malpractice.

The HIV-contaminated blood episode in France and England will be studied as an illustration of a case of healthcare failure and risks to patients at the public level and of the use of the criminal law in France. It will be used to explore the questions exposed above and shed light on the overall aim of the thesis, which is to assess what the role of the criminal law should be in the healthcare malpractice context. A wealth of material on the blood episode in France was accessible, in contrast to the more limited literature and data on the use of the criminal process more generally in healthcare. The case study within the project allowed us to conduct interviews with key stakeholders in the episode which shed light on the role of the criminal process in healthcare malpractice in France as a whole (see 1.3).

I seek to determine whether the substantive and procedural factors identified as being responsible for the greater use of the criminal process in France did impact on the way the criminal law was used in the HIV-contaminated blood episode in France and if there

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<sup>49</sup> See Ch3 pt3.6, 84.

were other factors at play which may have influenced the launch of criminal proceedings against healthcare providers in the episode. In particular, I compare the use of French and English criminal offences and features of French and English criminal procedure in the blood episode. I seek to find out whether lessons can be learned from the way in which the criminal law was used as a response to the HIV-contaminated blood episode in France. The blood episode is used to broaden the research to malpractice that occurs at the public level to determine whether criminal law should apply in cases of failure in the whole health service of a country. I will look at the question of whether the criminal law was an effective response to the HIV-contaminated blood episode in France, with regards to ensuring healthcare safety and responding to victims' demands. I attempt a comparative analysis of the outcome of the processes used in each country as responses to HIV-contamination of the blood supply and I identify what was a more effective approach for dealing with HIV blood contamination episodes. This will serve to help to answer the question of what role the criminal law should have in regulating healthcare malpractice episodes.

Drawing on from the factors identified as being responsible for the greater use of the criminal law in France and the way in which the criminal process was used in the HIV-contaminated blood episode in France but not in England, the thesis will examine whether lessons can be learnt from using substantive and procedural features of French criminal law as responses to healthcare malpractice. I focus on the use of the criminal law as a response to healthcare malpractice in general as part of dealing with broader issues relating to how to deal most effectively with episodes of healthcare malpractice. I then suggest the need to explore further alternative methods and systems which could prove more effective in dealing with episodes of healthcare malpractice.<sup>50</sup>

## **1.2. Background to Research**

In the chapters that follow, in attempting to analyse differences in the way French and English substantive criminal law and criminal procedure are used in healthcare malpractice, it is important to understand that French and English criminal systems come from different legal traditions, the civil law and the common law. The very nature of French and English criminal law has an impact on the way it is used in the context of

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<sup>50</sup> This thesis will however not discuss in great detail or propose specific alternatives responses to healthcare malpractice.



healthcare malpractice. French laws, including criminal law, are written and codified, whereas much of English law relating to homicide and offences against the person is based on common law, on judicial precedent.<sup>51</sup> The sources of French criminal law are criminal codes enacted by the Parliament (*Code Pénal* and *Code de Procédure Pénale*). In England and Wales, the most relevant part of criminal law can be found in a range of sources including statutes, case law, the common law, administrative guidelines and directions (eg CPS practice and policy).<sup>52</sup> The contrast between the sources of criminal law in France and England ie codes developed by the Parliament versus judge-made law, might impact on the way negligence is criminalised in France and England. As I will explain more fully in the next chapter, in France, negligence is criminalised much more generally than in England. French laws are normally to be found in general legal provisions in the Codes. For instance, the bases of the French law of negligence are set out in articles 1382 and 1383 of the *Code Civil* (Civil Code) which provide tort liability for intentional acts as well as for negligence, and article 121-3 of the *Code Pénal* (Penal code) which gives the general conditions for criminal liability for negligence.<sup>53</sup> The French legal system tends to generalise and provide abstract definitions whereas the English system is built on individual cases.<sup>54</sup> Van Caenegem acknowledges the ‘legalistic nature of codified systems, with a general aversion to discretionary (judicial) decision-making’.<sup>55</sup> As a consequence, negligence offences are generally set out by the Parliament in the *Code Pénal* in France. On the contrary, the evolution of GNM in England has been case driven. English criminal law does not contain a general criminal sanction for negligent conduct. There exist offences applicable in particular cases of negligence, for example road traffic offences or safety at work legislation, but there is no general criminalisation of negligence applicable in any context.<sup>56</sup>

Unlike English criminal law, French criminal law distinguishes between three levels of severity of criminal offences: *contraventions*, *délits*, *crimes*. *Crimes* are the most serious offences and may be punished between ten years and life imprisonment with a possible

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<sup>51</sup> The Offences Against the Person Act 1861 forms the basis of the law on non-fatal offences against the person but the development of the law depends largely on subsequent cases; K Zweigert, H Kotz, *An Introduction to Comparative Law* (3<sup>rd</sup> edn, Oxford University Press 1998) 69.

<sup>52</sup> C Van Den Wyngaert, *Criminal Procedure Systems in The European Community* (Butterworths 1993).

<sup>53</sup> Art 1382 *Code Civil* (CC); art 1383 CC; art 121-3 *Code Pénal* (CP).

<sup>54</sup> K Zweigert, H Kotz, above n 51.

<sup>55</sup> W Van Caenegem, *Advantages and Disadvantages of the Adversarial System in Criminal Proceedings*, Law Reform Commission of Western Australia, Review of the Criminal and Civil Justice System in Western Australia, Vol 1, 1999, 72.

<sup>56</sup> JR Spencer, MA Brajeux, above n46.

fine.<sup>57</sup> They are dealt with within the *Cour d'Assises*. *Délits* are major offences and may be punished up to 10 years imprisonment with a possible fine. They are dealt with in the *Tribunal correctionnel*.<sup>58</sup> *Contraventions* are the least serious offences and are only subject to a fine, dealt with within the *Tribunal de Police*.<sup>59</sup> This also has an impact on the use of negligence offences since they are listed in the *Code Pénal* as either *délits* or *contraventions*, which are not the most serious criminal offences. On the other hand in England, GNM might be seen as the third most serious charge in the 'criminal hierarchy' after treason and murder and can (in theory) attract a life sentence. Therefore, a prosecution for GNM in England is more serious than a prosecution for a negligence offence in France. I suggest that the very high level of which English criminal law sets liability for negligence makes it paradoxically harder to use criminal law to prosecute for GNM. A criminal prosecution or conviction for GNM in England involves a greater degree of stigma than a prosecution or conviction for negligence offences in France which are considered more minor offences and punished by maximum 5 years' imprisonment. This may add to the argument that France uses the criminal law as a regulatory tool.

Legal tradition which influenced the evolution of criminal procedure in France and England is also crucial here. Roman law, which influenced the French legal system up to the 18<sup>th</sup> century, led to the adoption in France of the inquisitorial type of criminal procedure.<sup>60</sup> As mentioned earlier, inquisitorial procedure is mainly characterised by strong involvement of the State especially during the pre-trial phase of the criminal proceedings. It also provided for a wide set of powers to be given to the *Ministère Public* and the *juge d'instruction*.<sup>61</sup> Importantly, it is characterised by a greater involvement of victims in the criminal process, who can join civil claims for compensation to a criminal complaint and thus launch a criminal prosecution.<sup>62</sup> They are then called '*parties civiles*'.<sup>63</sup> In theory, the purpose of the inquisitorial system is said to be more efficient than the adversarial system in the production of evidence since only legal professionals may examine the evidence in a case file.<sup>64</sup> On the contrary, England is based on an

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<sup>57</sup> Art 131-1 CP.

<sup>58</sup> Art 131-2 CP.

<sup>59</sup> Art 131-13 CP.

<sup>60</sup> C Elliott, *French Criminal Law* (Willan 2001) 2-3.

<sup>61</sup> Ibid.

<sup>62</sup> Art 2-3 *Code de Procédure Pénale* (CPP); B Boulloc, H Matsopoulou, *Droit pénal général et procédure pénale* (18<sup>e</sup> edn, Sirey 2011) 179, 197.

<sup>63</sup> Art 2-3 CPP; B Boulloc, H Matsopoulou, above n62.

<sup>64</sup> CM Bradley, Overview, in CM Bradley, JL Calamaras (eds), *Criminal Procedure, A Worldwide Study* (2<sup>nd</sup> edn, Carolina Academic Press 2007) xvii.

adversarial type of procedure, which implies the confrontation of two equal parties (the Crown and the accused) arbitrated by judges. The English adversarial procedure also involves a jury, who decides on guilt, whereas, it will be shown, in France, juries are not involved in criminal proceedings for negligence offences. I will demonstrate in the following chapters that the opposition between an inquisitorial and an adversarial system explains the differences in how healthcare malpractice is criminalised in France and England.

In France, both the *Code Civil* and the *Code Pénal* were products of the *Ancien Régime*, the French Revolution and the Napoleonic regime.<sup>65</sup> French laws result from a socialist background influenced by the 1789 Revolution, the importance of the ‘*Service Public*’, and the emphasis in the law and the Constitution on the interest of society or *Intérêt Général*. The French state is said to be a strong state.<sup>66</sup> A consequence of this is the *judiciarisation* (the recourse to courts) of public activities, in particular the *judiciarisation* of actions committed by officials or politics as a way of regulating public life, which could be demonstrated by the HIV-contaminated blood scandal in France.<sup>67</sup> This may suggest that because public activities may be subject to criminal liability, hospitals and doctors may be more vulnerable to criminal liability in France than in England even if they work in the public sector.

### 1.3 Methods and Sources

Having provided an outline of the main aims and themes of this research, I now turn to examining the methods and sources used in this research.

In undertaking a comparative analysis on the role of the criminal process in healthcare malpractice in France and England, I sought to address an under-researched area of the relevant academic literature. There is a number of books and articles on the general aims and functions of the criminal law in France and England.<sup>68</sup> The question of whether negligence should be criminalised has also been addressed.<sup>69</sup> There has been work done

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<sup>65</sup> K Zweigert, H Kotz, above n51 at 83, 86.

<sup>66</sup> H Machin, ‘Retooling the state machine’, in A Guyomarch, H Machin, PA Hall, J Hayward (eds), *Developments in French Politics 2* (Basingstoke: Palgrave, 2001) 139.

<sup>67</sup> Ibid 147; A Demichel, above n43 at 213.

<sup>68</sup> A Demichel, above n43 at 213-216; P Stella, ‘the Purpose and Effects of Punishment’ (2001) 9(1) *European Journal of Crime, Criminal Law & Criminal Justice* 56; A Ashworth, above n31; E Daskalakis, *Réflexions sur la responsabilité pénale* (Presses Universitaires de France 1975).

<sup>69</sup> RA Duff, ‘Whose Luck Is It Anyway’, in CMV Clarkson, S Cunningham (eds), *Criminal Liability for Non-Aggressive Death* (Ashgate 2008) 61; J Hall, ‘Negligent Behavior Should Be Excluded From Penal

on the impact of litigation and the criminal process on healthcare practice<sup>70</sup> in England and New Zealand, particularly as a result of the AHRC project on ‘The Impact of the Criminal Process on Health Care Ethics and Practice’, which I was involved in.<sup>71</sup> A number of academic articles studied the question of the role of criminal law in HIV transmission between sexual partners.<sup>72</sup> Other books and articles analysed the question of whether the use of the criminal law with regards to the HIV-contaminated blood episode was appropriate and whether criminal offences used in the blood episode in France were legally appropriate to apply to the type of actions that had been committed by healthcare officials.<sup>73</sup> However, these sources do not either compare the use of the criminal law in France and England in the HIV-contaminated blood episode or in the context of healthcare malpractice in general, or look at the question of whether the use of the criminal process was effective in ensuring blood safety and preventing healthcare disasters. I try to address this gap in this thesis.

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Liability’ (1963) 63(4) *Columbia Law Review* 632, 644; Y Mayaud, ‘Les délits non intentionnels en matière pénale’ (2008) *Revue de droit sanitaire et social* 49; M Gand, *Du délit de commission par omission: essai de théorie pénale* (A Rousseau 1900); JP Doucet, *La protection pénale de la personne humaine, Vol 1: La protection de la vie et de l’intégrité corporelle* (3<sup>e</sup> edn, Gazette du Palais Diffusion Litec 1994).

<sup>70</sup> O Quick, ‘Medicine, mistakes and manslaughter : a criminal combination ?’, above n35 at 186-203; A Merry, ‘How does the law recognize and deal with medical errors?’ (2009) 102 *Journal of the Royal Society of Medicine* 265; A McCall Smith, ‘Clinical Negligence and the Incompetent Doctor’ (1993) 1(3) *Medical Law Review* 336; O Quick, ‘Medical Killing : Need for a Specific Offence ?’, above n35 at 155-175; D Viriot-Barrial, ‘Le droit pénal face aux grandes catastrophes sanitaires’ (2008) *Revue de droit sanitaire et social* 21; D Dreyfuss, F Lemaire, H Outin (eds), *La Judicialisation de la médecine* (Médecine-Sciences Flammarion 2004); J Guigue, ‘Les inconvénients de la pénalisation du droit de la santé’ (2008) *Revue de droit sanitaire et social* 36; I Jamin, ‘La responsabilité pénale en milieu de soins: une préoccupation réelle, une menace relative?’ (2009) *Actualité Juridique Pénal* 340 ; T Cassuto, ‘Réflexions sur la pratique de la responsabilité médicale en matière pénale’ (2009) *Actualité Juridique Pénal* 337 ; V Wester-Ouisse, above n44 at 245 ; A Merry, A McCall Smith, above n1.

<sup>71</sup> C Erin, S Ost (eds), *The Criminal Justice System and Health Care* (Oxford University Press 2007); D Griffiths, A Sanders, ‘The road to the dock: prosecution decision-making in medical manslaughter cases, in D Griffiths and A Sanders (eds), *Medicine, Crime and Society* (Cambridge University Press Forthcoming 2013) 117-158; D Griffiths, A Alghrani, ‘Criminal Health Care Professionals: Medical Malpractice and Public Perceptions’ (Unpublished); A Alghrani et al., ‘Health care scandals in the NHS: Crime and punishment’ (2011) 37(4) *Journal of Medical Ethics* 230; M Brazier, A Alghrani, ‘Fatal Medical Malpractice and Criminal Liability’ (2009) 25(2) *Journal of Professional Negligence* 51; C Wells, ‘Medical manslaughter, organisational liability’, in D Griffiths and A Sanders (eds), *Medicine, Crime and Society* (Cambridge University Press Forthcoming 2013) 192-209; P Gooderham, B Toft, ‘Involuntary automaticity and medical manslaughter’, in D Griffiths and A Sanders (eds), *Medicine, Crime and Society* (Cambridge University Press Forthcoming 2013) 177-191.

<sup>72</sup> LE Wolf, R Vezina, ‘Crime and Punishment : Is There a Role for Criminal Law in HIV Prevention Policy?’ (2004) 25 *Whittier Law Review* 821.

<sup>73</sup> M Bernard-Requin, ‘SIDA et transfusion sanguine ou l’affaire du sang contaminé. Les difficiles qualifications pénales’ (1998) 28(1) *Médecine et Maladies Infectieuses* 15 ; J Pradel (Dir), *Sang et droit pénal. A propos du sang contaminé*, Travaux de l’Institut de sciences criminelles de Poitiers (Edition Cujas 1995); MA Hermitte, *Le sang et le droit. Essai sur la transfusion sanguine* (Seuil 1996) ; C Bonah, E Lepicard, V Roelcke, *La médecine expérimentale au tribunal. Implications éthiques de quelques procès médicaux du XXe siècle européen* (Edition des archives contemporaines 2003).

Within the original case study as part of the AHRC project and in the decision to focus on France and England, we concluded that a qualitative comparative methodology based on these two countries offered useful opportunities to analyse the factors noted above. The use of a qualitative methodology permitted an in-depth analysis and understanding of the two systems and their responses to healthcare malpractice. The use of a qualitative comparative methodology allowed an investigation of the reasons why England and France choose a different approach to deal with a similar problem and to analyse how both countries respond to the said problem. The outcome of using such a methodology was to produce information on the particular case studied but any general conclusion drawn from the case study will only be hypothetical. As acknowledged by Lijphart, ‘scientific search should be aimed at probabilistic, not universal, generalizations’.<sup>74</sup> The results of this study can be very useful to both law and healthcare, in both France and England as well as in other countries.<sup>75</sup> Indeed, ‘partial generalizations may be useful as a first step and may be followed up by replications in different settings’.<sup>76</sup> Comparing the role of the criminal law in healthcare malpractice in France and England as a case study aims at examining it ‘in its real-life context’.<sup>77</sup> This will allow building hypotheses which will be ‘generalisable to theoretical propositions’ on whether the criminal process is a right tool to regulate healthcare malpractice as well as to test some of the assertions made out in earlier work by the authors cited above.<sup>78</sup>

When I moved to my broader study of the role of criminal law in healthcare malpractice in France and England, I chose to use a comparative law methodology.<sup>79</sup> A comparative law methodology aims at isolating the ‘factors which actually have led to a real innovation in a particular society’.<sup>80</sup> Using a comparative law methodology will help me in my aim to determine ‘whether and how far it is reasonable to borrow’ from the French system, and ‘whether it is possible to accept’ the French solution ‘with modification or without modification’.<sup>81</sup> Thus, I will discuss whether the way in which France criminalises healthcare malpractice should be used as a model for change in England.

<sup>74</sup> A Lijphart, ‘Comparative Politics and the Comparative Method’ (1971) 65(3) *American Political Science Review*, 686.

<sup>75</sup> G King, RO Keohane, S Verba, *Designing Social Inquiry* (Princeton, 1994) 12-22.

<sup>76</sup> A Lijphart, above n74 at 686.

<sup>77</sup> RK Yin, ‘The Case Study Crisis: Some Answers’ (1981) 26(1) *Administrative Science Quarterly*, 59; RK Yin, *Case Study Research: Design and Methods* (4<sup>th</sup> edn, Thousand Oaks, Calif., Sage 2009) 13.

<sup>78</sup> RK Yin, *Case Study Research: Design and Methods* above n77 at 10.

<sup>79</sup> P de Cruz, *Comparative Law in A Changing World* (3<sup>rd</sup> edn, Routledge-Cavendish 2007) 1-5.

<sup>80</sup> A Watson, *Legal Transplants. An Approach to Comparative Law* (2<sup>nd</sup> edn, The University of Georgia Press 1993) 16; G Dannemann, ‘Chapter 11: Comparative Law: Study of Similarities of Differences?’, in M Reimann, R Zimmermann (eds), *The Oxford Handbook of Comparative Law* (Oxford University Press 2008) 397.

<sup>81</sup> A Watson, above n80 at 16; G Dannemann, above n80 at 410.

However, this type of comparative methodology has its limits. Dannemann explains that the ‘differences between legal systems and their historical, economic, social, geographical, political and cultural contexts are often too great to allow safe conclusions about the effect which certain rules will produce outside their native environment’.<sup>82</sup> But he argues that this kind of study can still ‘produce more evidence [...] than an enquiry which limits itself to one legal system’.<sup>83</sup>

I have used both primary and secondary sources for the purpose of my research. Primary sources included French and English statutes, French legal codes, and French and English case law in relation to negligence causing injury or death. Secondary sources included academic books and articles, including the literature and some of the findings produced during the AHRC project. My claims regarding the number of criminal prosecutions and convictions against doctors in France are limited by the absence of official statistics as of yet in this area.<sup>84</sup> I also made use of the Internet for background information and to access reports, newspapers articles, journal articles and legislation.

Both primary and secondary sources have been used to investigate on the HIV-contaminated blood scandal in France. Primary sources included scientific and medical articles on HIV/AIDS published between 1980 and 1986, the Lucas Report<sup>85</sup>, minutes of CNTS<sup>86</sup> or ministerial meetings, decisions and circulars joined to the Lucas Report, statutes, the *Ministère Public*’s *réquisitions*<sup>87</sup> and the decision of the *Tribunal Correctionnel*<sup>88</sup> in the first set of proceedings, investigative files of the second and third sets of criminal proceedings, *réquisitions* and courts’ decisions of the third set, as well as other courts’ decisions. Secondary sources included newspapers articles<sup>89</sup>, parliamentary

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<sup>82</sup> G Dannemann, above n80 at 398.

<sup>83</sup> Ibid 399.

<sup>84</sup> N Gombault, ‘Conséquences de la judiciarisation de la médecine dans la relation médecin-malade’, in D Dreyfuss, F Lemaire, H Outin (eds), D Dreyfuss, F Lemaire, H Outin (eds), *La Judiciarisation de la médecine* (Médecine-Sciences Flammarion 2004) 2; Interview with Marie-Odile Bertella-Geffroy (Paris, France, 18 January 2011) 15.

<sup>85</sup> Name given to the report made by Michel Lucas, inspector general of health in France in 1991 on the decision-making process of doctors, health officials and health authorities in the HIV-contaminated blood episode in France. The report makes use of minutes of meetings, articles of scientific and medical journals, circulars and legislation, letters and administrative notes, and data and results of working groups on HIV/AIDS; M Lucas, *Transfusion Sanguine et SIDA en 1985, Chronologie des faits et des décisions pour ce qui concerne les hémophiles*, Inspection Générale des Affaires Sociales, Septembre 1991.

<sup>86</sup> CNTS was the *Centre National de Transfusion Sanguine* (National Blood Centre) in France. Its role and functions will be developed in Ch4 pt4.3, 99.

<sup>87</sup> Document in which the *Ministère Public* either closes the case or sends the case to court, in which case it will require certain charges against the accused. B Boulloc, above n41 at 767.

<sup>88</sup> The *réquisitoire de renvoi* and the decision of the *Tribunal correctionnel* in the first set of criminal proceedings are contained in L Greilsamer, *Le procès du sang contaminé* (Le Monde Editions 1992).

<sup>89</sup> *Le procès du sang contaminé* also included *Le Monde* articles published during the first set of criminal proceedings.

reports, the Lucas Report, academic articles and books, and non-academic books. The courts' reports and prosecution documents of the blood episode in France provided capital information on *juges d'instruction*'s investigations and findings, allegations against the accused and the defendants' arguments, as well as victims' demands and allegations. Other reports and scientific or medical articles provided crucial background information on the chronology of the knowledge of HIV/AIDS by the medical profession at the time and the decision-making process of health officials and authorities to respond to the contamination. Interviews conducted as part of my research in Paris and Cambridge (see below) provided with central information on *juges d'instruction*'s, prosecutors', victims' and defendants' points of view on the role of the criminal process in the episode as well as the role of the media and the public in the scandal and their influence on the use of criminal proceedings.

The thesis also made use of both primary and secondary sources to investigate on the HIV-contaminated blood episode in England. Primary sources included official reports, scientific and medical articles, cases, legislative documents, parliamentary debates and the documents released by the Department of Health following the *HIV Haemophiliac Litigation*<sup>90</sup>, as well as primary sources found on [www.taintedblood.info](http://www.taintedblood.info)<sup>91</sup>. Secondary sources included academic books and articles, newspaper articles and the Archer Inquiry Report<sup>92</sup>. Many English sources have substantial information on the contamination with Hepatitis C<sup>93</sup> but limited material on the HIV-contamination. Moreover, the disclosure of official and unofficial documents on actions undertaken against the contamination (minutes of meeting or administrative correspondence etc.) was restricted in England and several documents were lost.<sup>94</sup> This material provided relevant information on the knowledge on HIV/AIDS of scientists and doctors at the time of the episode, the decision-making process of blood authorities in responding to the contamination, victims' demands for accountability and compensation, the attitude of the Department of Health in refusing to respond to victims' demands and the role of the media in the episode.

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<sup>90</sup> [1990] 41 BMLR 171.

<sup>91</sup> Website dedicated to contaminated Haemophilia patients. It contains documentation and resources, a chronology on contaminations of blood and other bodily products since 1948 and a page on victims of the contamination; see <[www.taintedblood.info](http://www.taintedblood.info)>.

<sup>92</sup> Rt Hon Lord Archer of Sandwell QC, Independent Public Inquiry Report on NHS Supplied Contaminated Blood and Blood Products, 23 February 2009.

<sup>93</sup> From the 1970s and until mid 1980s, many PWH in the UK became contaminated with Hepatitis C as a result of treatment with blood and blood products. This scandal is dealt with in the Archer Inquiry Report. Rt Hon Lord Archer of Sandwell QC, above n92 at 5.

<sup>94</sup> Rt Hon Lord Archer of Sandwell QC, above n92 at 67.

As part of my qualitative research study, I conducted empirical work<sup>95</sup> in Paris (France) and Cambridge (England) assisted by my PhD supervisor Dr Anne-Maree Farrell. It consisted of semi-structured interviews involving key stakeholders of the HIV-contaminated blood episode in France. They involved Marie-Odile Bertella-Geffroy, the *juge d'instruction* who was in charge of investigating the HIV-contaminated blood case in the third set of criminal proceedings and is currently in charge of cases of healthcare malpractice in the *pole de santé publique*<sup>96</sup> in Paris. An anonymous doctor was also interviewed. An interview was also conducted with Doctor Dominique Marchetti, a sociologist who worked on the role of the media and journalists in the contaminated blood scandal in France.<sup>97</sup> It was decided to conduct interviews to explore the use of the criminal process in the HIV-contaminated blood episode in France as well as to investigate the more general question of the role of the criminal law in healthcare in France. An empirical study that addressed the questions relating to the whole range of criminal investigations of healthcare malpractice was beyond the scope of this thesis and would constitute more than a single thesis on its own. Marie-Odile Bertella-Geffroy was chosen because of her expertise in the blood case which is a crucial case in the area of healthcare malpractice. Conducting empirical work in the form of semi-structured interviews permitted me to obtain information on both issues to fill in the gaps of my research on the blood episode and the role of the criminal process in healthcare in France. Interview data was interpreted using grounded theory to identify key concepts and themes. I analysed the interviews through qualitative data analysis and I coded the interview data according to themes. The approach taken allowed me to build theories and develop analyses which were checked by gathering further data.<sup>98</sup> It is recognised that there are limitations to the approach taken to this study. The small number of stakeholders interviewed was such that I was unable to generalise about any findings. My interpretation of the interview data was subjective in the way that I selected themes as the interpretation might have been different if other themes had been selected. Nevertheless the interviews provided valuable information in support of my research and assisted me in the framing of my argument.

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<sup>95</sup> Approval was given from the Ethics Committee to conduct these interviews. Throughout the thesis, page references are given to the transcripts of the interviews (See Appendix 1).

<sup>96</sup> *Pôles de santé publique* are authorities within criminal courts which are in charge of investigating cases of dangerous health products, foods or substance which have caused multiple victims; art 706-2 CPP ; M Obadia, 'L'expérience d'un pôle de santé publique' (2008) *Revue de droit sanitaire et social*, 44; MO Bertella-Geffroy, 'Justice Pénale, Santé Individuelle et Santé Publique' (2008) 128(2) *Droit de la Santé*; See ch3 pt3.4.1, 71.

<sup>97</sup> D Marchetti, above n8.

<sup>98</sup> D Silverman, *Interpreting Qualitative Data* (4<sup>th</sup> edn, Sage 2011) 67; M David, C Sutton, *Social Research* (2<sup>nd</sup> edn, Sage 2011) 102.



Contact with the victims or advocates of victims was difficult to make. Contact was made with the *Association Française des Hémophiles* (AFH) but they did not respond to our request. Contact was made with several victims' advocates. Only one agreed to be interviewed but cancelled at the last minute. The reluctance of the victims to be interviewed on the matter reflects how painful the episode was for them. Therefore, the claims made in this thesis on the role of victims in criminal proceedings arising out of the contaminated blood scandal in France are limited. However, the interview with Marie-Odile Bertella-Geffroy who has frequent contact with victims and knows their motivations to use the criminal law, as well as accounts given in newspaper articles provided insight of the victims' situation and demands.

The aim of the interviews was to gather additional information on the role of the media, the public, the role of different actors involved in criminal proceedings, specifically the role of victims, judges, the *Ministère Public*, experts and the accused on the use of criminal law in the HIV-contaminated blood episode in France. The aim was also to gather different perspectives on the question of whether criminal law is appropriate and efficient to deal with healthcare malpractice. The interviews helped us understand and discover key facts and issues that have not been discussed in the available academic literature on the HIV blood contamination scandal in France. From the information collected, I was able to compare diverse points of view (the *juge d'instruction*'s and the defendants' points of view, and critical and objective point of view from a researcher), and to analyse differing perspectives on the matter. The data collected from the interview is analysed regarding hypotheses made in the thesis to determine whether the data weakens or strengthens arguments generated as part of the research.<sup>99</sup> I used the data collected from the interviews to determine the proper role of the criminal law in healthcare malpractice and the deterrent effect of criminal proceedings on healthcare practitioners and officials.

The analysis of the HIV-contaminated blood episode decades later also allowed a more neutral approach to the events, not influenced by a climate of outrage as it would have been the case if the thesis was written at the time of the episode. The interview with Marie-Odile Bertella-Geffroy provided valuable information on the way doctors are criminalised in France for healthcare malpractice and what victims want from using the criminal law, as well as the mechanisms of criminal prosecutions involving medical professionals, which are not necessarily detailed in criminal law books.

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<sup>99</sup> T Wengraf, *Qualitative Research Interviewing* (Sage Publications 2006) 235.

## **1.4 Organisation of Research**

Following on from this introductory chapter, Chapters 2 and 3 provide a comparison of French and English substantive criminal law and criminal procedure as used in the context of healthcare malpractice. Chapter 2 shows that French criminal law admits the criminalisation of simple negligence and negligence resulting in injury short of death while English criminal law only admits the criminalisation of gross negligence resulting in death and this in part explains the wider use of the criminal law in France in the context of healthcare malpractice. Chapter 3 focuses on dissimilarities between French and English criminal procedures and their impact on the criminalisation of healthcare malpractice. Features of the French inquisitorial procedure provide for a greater scope for prosecuting doctors for negligence than features of the English adversarial procedure. The main aim of the comparative analysis in Chapters 2 and 3 is to determine whether features of criminal law are suited to apply to healthcare malpractice cases and whether aspects of French criminal law should be regarded as models for change in England.

Chapters 4-6 focus on the use of the criminal law in the HIV-contaminated blood episode in France and England, used as an example of the wider criminalisation of healthcare malpractice in France. These three chapters analyse the use of the criminal process in the blood episode in both countries, to help address the issue of whether the use of the criminal law in the episode was effective to ensure blood safety and respond to victims' demands and whether the criminal process is an effective means to regulate healthcare malpractice. Chapter 4 compares the level of culpability of doctors and health officials in failing to respond to the HIV-contamination of the blood supply in France and England so as to find out whether French doctors and officials had a greater level of moral culpability which justified the use of the criminal law in France. Drawing on the conclusions made in Chapters 2 and 3, the aim of Chapter 5 is to compare the role of the criminal law and criminal process in the contaminated blood episode in France and England and to determine whether factors identified in Chapters 2 and 3 were also influential in the blood episode. I raise the issue of whether English substantive criminal law and criminal procedure could have been used in response to the blood contamination. I demonstrate that some features of French criminal law and criminal procedure as well as political and social factors influenced the use of the criminal process. Chapter 6 looks at the question of whether substantive criminal law and the criminal process were effective in ensuring blood safety and in responding to victims' demands.

Following on from the conclusions made in these chapters, the aim of Chapters 7 and 8 is to explore further the proper role of the criminal law in healthcare malpractice, and whether England should look at France for a model for change. The aim of Chapter 7 is to determine what role, if any, criminal law should play in individual healthcare malpractice. I consider the issue of whether England should look at France for a model of criminalisation of healthcare malpractice, particularly whether French negligence offences could be used to inform English current response to healthcare malpractice and whether some elements of French criminal procedure could be used to inform responses to healthcare malpractice. The chapter looks at the effectiveness of the criminal process in ensuring healthcare safety and responding to victims' demands, envisaging alternatives to the criminal process which could prove more appropriate and more effective to deal with cases of individual healthcare malpractice. In Chapter 8, I explore the question of whether and how health institutions and managers should be criminalised for malpractice. I look at the usefulness of the criminal process in holding health institutions and/or senior managers and health officials to account for errors. I argue that the criminal process is not always the most desirable solution to corporate healthcare malpractice but the role of the Health and Safety at Work Act 1974 in the criminalisation of health institutions is not to be dismissed, and I demonstrate the need for some alternative processes which could ensure healthcare safety and prevent systems error.

The concluding chapter briefly summarises the main arguments and key findings from my research.

## 2. The Role of the Criminal Law in Regulating Healthcare Malpractice in France and England

### 2.1 Introduction

Until relatively recently, in France and England the medical profession enjoyed a certain status of deference.<sup>1</sup> The deference attached to doctors resulted in few claims of any kind (civil or criminal) being made against them. Although, no formal immunity existed.<sup>2</sup> Brazier and Allen have claimed that ‘it may sometimes have appeared that doctors enjoyed a special status close to immunity from the usual rigours of the law’.<sup>3</sup> It was argued that patients had an absolute trust in their doctors and any unexpected damage caused to their body as a result of a medical treatment was seen as a consequence of fate, not a result of the doctor’s negligence.<sup>4</sup> In the last three to four decades, there has been a growing number of civil claims for clinical negligence in France and England and the culture of deference is on the decline.<sup>5</sup>

In France, the *Ordre des Médecins*<sup>6</sup> received 1225 complaints about fitness to practice in 2010 compared to 1147 in 2007.<sup>7</sup> In 2009/10 in England, the National Health Service Litigation Authority (NHS LA) registered 6652 claims for clinical

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<sup>1</sup> C Sureau, ‘L’erreur, la faute, l’aléa, sanction ou prévention?’, in C Sureau, D Lecourt, G David, *L’erreur médicale* (Sem.) (Presses Universitaires de France 2006) 23; M Brazier, N Allen, ‘Criminalizing Medical Malpractice’, in C Erin, S Ost (eds), *The Criminal Justice System and Health Care* (Oxford University Press 2007) 15.

<sup>2</sup> C Sureau, above n1 at 23; M Brazier, E Cave, *Medicine, Patients and the Law* (5<sup>th</sup> edn, Penguin Books 2011) 155; M Brazier, N Allen, above n1 at 15.

<sup>3</sup> M Brazier, N Allen, above n1 at 15.

<sup>4</sup> C Sureau, above n1 at 23.

<sup>5</sup> Lord Woolf, ‘Are the Courts Excessively Deferential to the Medical Profession?’ (2001) 9 *Medical Law Review*, 1-3; C Sureau, above n1 at 23-41.

<sup>6</sup> The *Ordre des médecins* is a disciplinary body in charge of assuring that ‘principles of morality, integrity, competence and devotion which are essential to good medical practice, professional duties and rules from the *Code de déontologie médicale*’, are applied (art L4121-2 *Code de la Santé Publique*). It is the equivalent of the General Medical Council (GMC) in England. *Code de déontologie médicale* enumerates professional duties for doctors to fulfil (art R.4127-1 to R.4127-112 *Code de la Santé Publique*).

<sup>7</sup> Statistics from the *Ordre des Médecins* (sent via email); See appendix 2.

negligence against 6088 in 2008/9, a rise of nearly 10%.<sup>8</sup> The NHSLA does not have a French equivalent and so statistics in France do not indicate the number of civil claims against doctors and hospitals. But for the purposes of this thesis, what can be discerned is that there has been substantial rise to resort to redress in civil or disciplinary proceedings in both countries. This chapter and the next chapter are concerned however with the role of substantive criminal law and criminal procedure in healthcare malpractice in France and England.

It has been suggested that the last 10 to 20 years have seen an increase in the use of the criminal law against healthcare professionals in France and England, although there are no official statistics in either country to confirm the number of doctors prosecuted or convicted for charges relating to professional errors committed in the course of their employment.<sup>9</sup> It is argued that criminal prosecutions against doctors and health officials for negligence have increased in France since the 1990s.<sup>10</sup> Daury-Fauveau notes that in France from 1990 to 2000, around 102 doctors and medical professionals were convicted (for all types of offences).<sup>11</sup> Even though there are no official statistics in that area, the following figures indicate that there is evidence to say that there are more prosecutions of doctors for charges relating to malpractice in France than in England. Generally, approximately 33% of investigated cases of healthcare malpractice lead to criminal prosecutions in France.<sup>12</sup> Nearly 66% of criminal prosecutions against doctors lead to convictions.<sup>13</sup> Nevertheless, even in France, criminal convictions of doctors (for all types of offences) are still very rare compared to the number of medical acts.<sup>14</sup> In England, prosecutions of medical professionals for negligence

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<sup>8</sup> See <[www.nhs.uk](http://www.nhs.uk)>, *Factsheets 1-5*; A freedom of information request was made to the GMC regarding the number of claims and decisions made against doctors in the GMC in the recent period. A response from the GMC said that the information could not be obtained because of the cost to investigate the matter.

<sup>9</sup> S Ost, C Erin, 'An Ill-Suited and Inappropriate Union? Exploring the Relationship Between the Criminal Justice System and Health Care', in C Erin, S Ost (eds), *The Criminal Justice System and Health Care* (Oxford University Press 2007) 2; D Griffiths, A Sanders, 'The road to the dock: prosecution decision-making in medical manslaughter cases', in D Griffiths and A Sanders (eds), *Medicine, Crime and Society* (Cambridge University Press Forthcoming 2013) 117-158; RE Ferner, SE McDowell, 'Doctors charged with manslaughter in the course of medical practice, 1795-2005: a literature review' (2006) 99 *Journal Of the Royal Society of Medicine* 309; Interview with Marie-Odile Bertella-Geffroy (Paris, France, 18 January 2011) 15.

<sup>10</sup> M Daury-Fauveau, *La responsabilité pénale du médecin* (Les études hospitalières 2003) 5.

<sup>11</sup> Ibid 1.

<sup>12</sup> MO Bertella-Geffroy, 'Justice pénale, santé individuelle et santé publique' (2008) 128(2) *Droit de la santé*, 9.

<sup>13</sup> Sou Médical, Rapport d'activité 2011 sur le risque des professions de santé, 79.

<sup>14</sup> There are approximately 20 criminal decisions a year for 400000 medical acts a year, and between 1999 and 2003 around 350 criminal complaints against doctors were recorded. MO

remain rarer still. As acknowledged in Chapter 1, Ferner's research on English newspapers from 1795 to 2005 suggested that prosecutions for 'medical manslaughter' had increased greatly since 1990.<sup>15</sup> However, Griffiths' and Sanders' research on Crown Prosecution Service (CPS) files has shown that prosecutions against doctors for negligence remain very few, even in the recent period.<sup>16</sup> Unlike in France, only 5% of investigated cases of 'medical manslaughter' lead to prosecutions in England.<sup>17</sup> Approximately 40% of 'medical manslaughter' cases lead to conviction in England.<sup>18</sup>

In England, there has however been an increase in investigations by coroners and the police against health professionals, which may show a general trend for the criminalisation of healthcare malpractice in both countries.<sup>19</sup> As I will discuss later in this chapter, prosecutions for criminal negligence in England have a much more limited scope than in France. Yet, as mentioned in Chapter 1, in the last 10 years, two reforms undertaken in 2000 and 2002 may have had an impact on the use of the criminal law in this context in France.<sup>20</sup> The aim of the *Loi Fauchon* in 2000 was to 'restore a balance between punishment and reparation'.<sup>21</sup> The no-fault compensation scheme set up in 2002 aimed to limit the scope of healthcare malpractice litigation.<sup>22</sup> Thus, even though the scope for criminalising healthcare malpractice is broader in France, these reforms might have limited it. This leads to the much broader question of whether criminal law is a right way to deal with negligent conduct in the healthcare setting, which I discuss in Chapters 7 and 8.<sup>23</sup>

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Bertella, above n12 at 9; T Cassuto, 'Réflexions sur la pratique de la responsabilité médicale en matière pénale' (2009) *Actualité Juridique Pénal* 337.

<sup>15</sup> RE Ferner, SE McDowell, above n9 at 309.

<sup>16</sup> D Griffiths, A Sanders, above n9.

<sup>17</sup> Ibid.

<sup>18</sup> Ibid.

<sup>19</sup> Ibid 2.

<sup>20</sup> See ch1, 18.

<sup>21</sup> Assemblée Nationale, Rapport N° 2266 fait au nom de la commission des lois constitutionnelles, de la législation et de l'administration générale de la République sur la proposition de loi, adoptée par le Sénat, tendant à préciser la définition des délits non intentionnels, par M René Dosièrre, 22 mars 2000, 48.

<sup>22</sup> Loi n° 2002-303 du 4 mars 2002 relative aux droits des malades et à la qualité du système de santé; S Taylor, 'Providing Redress for Medical Accidents in France: Conflicting Aims, Effective Solutions?' (2011) 2(1) *Journal of European Tort Law* 61.

<sup>23</sup> I have not been able to discover anymore recent figures on the desire of healthcare malpractice victims to use the criminal process in France. However, a survey conducted by the SOFRES (*Société française d'enquête par sondage*, French public opinion poll institute) in France found that 71% of the persons interrogated would wish to ask a doctor or hospital to be prosecuted if one of their family members were to be victim of healthcare malpractice. This indicates that in

This chapter compares French and English substantive criminal law in relation to death or injury caused by negligence, and begins to assess the impact of rules of substantive criminal law on accountability for healthcare malpractice and for failures in the healthcare system in France and England. Fundamental differences in the framing of principles in criminal law play a major role in explaining different responses in France and England to healthcare malpractice. The French *Code Pénal* allows a more generalised criminalisation of negligent conduct than English case law. In England, a doctor's mistake might be terrible, but if it did not cause the death of the patient, the doctor would not be prosecuted. In England, only gross negligence manslaughter (GNM) is usually used in the healthcare context. On the other hand, in France, simple negligence and conduct resulting in injury short of death is criminalised. French criminal law provides for a broad range of offences used in the context of healthcare malpractice. It will be demonstrated that some English equivalents could apply to cases of healthcare malpractice in England but they are not used. In England, the current test of gross negligence is circular and unclear and so, seems to reduce the scope for prosecutions of doctors for malpractice. I will begin to assess the disadvantages of using the gross negligence test which will be further discussed in Chapter 7.<sup>24</sup> Furthermore, I will show that even after the *Loi Fauchon*, French courts seem to admit a more victim-oriented approach to causation, which also helps to explain the greater rates of prosecutions and convictions against doctors for malpractice.

This chapter will be necessarily somewhat descriptive as to differences between French and English criminal law in the context of healthcare malpractice. A detailed comparison of these differences in both countries is essential for the examination of the role of the criminal law in healthcare malpractice in general. It must be made clear that I do not endorse the French model of criminalisation in the context of healthcare malpractice and will rather argue in Chapters 7 and 8 that the criminalisation of healthcare malpractice should be limited to conduct amounting to recklessness. In this chapter, I seek to show how French law offers a broader view for criminal law and note any benefits this may bring in the context of healthcare malpractice.

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France, victims of healthcare malpractice show a pronounced propensity to use the criminal process.

<sup>24</sup> See ch7 pt7.2.2, 204.

## 2.2 The Criminalisation of Negligence in French and English Criminal Law

French and English criminal laws take a different view to negligence, which, I shall demonstrate, explains the greater scope for criminalisation of healthcare malpractice in France. The starting point in both English and French criminal law is that a criminal offence normally requires *mens rea* (guilty mind). A fundamental principle in French criminal law is the requirement of intention to commit a criminal offence: ‘there is no felony or misdemeanour in the absence of intent to commit it’.<sup>25</sup> Criminal offences in French law will usually require intention. However, negligence in French criminal law is stated as an exception to the requirement of intention for all criminal offences against the person, justified by the importance of protecting the bodily integrity of a person: ‘in the case of negligent homicide and negligent injury, the importance of protecting human life and the integrity of the human body are thought to justify a major exception’.<sup>26</sup> This adds to the argument made in Chapter 1 that France uses the criminal law as a regulatory tool in the context of damage to the person including healthcare malpractice. As we shall see, in England, negligently causing bodily injury short of death is a criminal offence only in specific contexts, in particular, in the context of road traffic offences<sup>27</sup>, health and safety at work<sup>28</sup>, wilful neglect of mentally ill or incapacitated patients<sup>29</sup>, (arguably) grievous bodily harm<sup>30</sup> or child neglect<sup>31</sup>.

In France, negligence is stated in article 121-3 of the *Code Pénal* as being a criminal offence: ‘a *délit*<sup>32</sup> also exists, where the law so provides, in cases of recklessness, negligence, or failure to observe an obligation of due care or precaution imposed by any statute or regulation, where it is established that the offender has failed to show normal diligence, taking into consideration where appropriate the nature of his role or functions, of his capacities and powers and

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<sup>25</sup> Art 121-3 CP.

<sup>26</sup> JR Spencer, MA Brajeux, ‘Criminal liability for negligence-A lesson from across the Channel?’ (2010) 59(1) *International and Comparative Law Quarterly* 16.

<sup>27</sup> Road Traffic Act 1988 s 1, s 3A, s 2B, 3ZB.

<sup>28</sup> HSWA 1974 s 7.

<sup>29</sup> Mental Health Act 1983 s 127; Mental Capacity Act 2005 s 44.

<sup>30</sup> Offences Against the Person Act 1861 s 20.

<sup>31</sup> Children and Young Persons Act 1933 s 1.

<sup>32</sup> *Délit* is the second category of criminal offences in French criminal law.



of the means then available to him'.<sup>33</sup> This definition is very close to how Ashworth would want to define criminal negligence in England. He claims that as long as a person had the capacity to take necessary precautions in order to avoid the damage to be caused, he should be criminally liable for causing the damage.<sup>34</sup>

Thus in France, any individual, including healthcare professionals and officials<sup>35</sup>, may be criminally liable for negligence offences, whether his conduct amounted to simple negligence, recklessness or failure to observe an obligation of security or care. This article is at the basis of all *fautes* (negligent conduct) which are considered criminal in French law.<sup>36</sup> This article applies to all types of situation where negligence may cause serious damage, including road traffic, work accidents and the delivery of healthcare.<sup>37</sup>

In England, there has never been a general principle for criminalising negligence. The most 'general' offence of negligence is gross negligence manslaughter (GNM), which evolved through the cases since the 19<sup>th</sup> century.<sup>38</sup> As mentioned earlier, in England, beside GNM, criminal negligence is found in a range of negligence and strict liability offences created to apply to specific contexts. The lack of a general criminalisation of negligence in English law leads to inconsistencies in the penalisation of negligent conduct. For example, if a parent neglects his child, the parent could be criminally liable under the Children and Young Persons Act 1933.<sup>39</sup> But if a family of a dependent and vulnerable adult neglects him, the family members will not be criminally liable for the damage caused by the neglect unless he dies or was mentally incapacitated.<sup>40</sup> Neglect might be morally atrocious, but may not necessarily be criminal in England. This leaves great scope for moral luck as criminal liability only depends on the outcome of the conduct. On the contrary, the *Code Pénal* provides for the criminalisation of different levels of moral culpability in negligence which may or may not result in death.

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<sup>33</sup> Art 121-3 al 3 CP.

<sup>34</sup> A Ashworth, *Principles of Criminal Law* (6<sup>th</sup> edn, Oxford University Press 2009) 187.

<sup>35</sup> This will be well illustrated in the analysis of the HIV-contaminated blood episode where both doctors and health officials were prosecuted for negligence offences in France. See ch4, 5 and 6.

<sup>36</sup> Y Mayaud, *Violences involontaires et responsabilité pénale* (Dalloz Référence 2003) 5.

<sup>37</sup> Assemblée Nationale, Rapport N° 2266 above n21 at 12.

<sup>38</sup> A Ashworth, above n34 at 276-277.

<sup>39</sup> Children and Young Persons Act 1933 s 1.

<sup>40</sup> Mental Capacity Act 2005 s 44; JR Spencer, MA Brajeux, above n26 at 3.

## 2.3 Criminal Offences Used in the Context of Healthcare Malpractice in France and England

The greater range of specific negligence offences which may apply in the context of healthcare malpractice in France is a major factor explaining the greater use of the criminal law against doctors. In France, the general principle that negligently causing injury can constitute crime and the imposition of a duty to rescue mean that many instances of medical error or poor practice that would be at most a civil wrong in England are criminal offences in France and so, as we will see in the next chapter, enabling the victim to take advantage of redress via the criminal process.

It is important to note that, as mentioned in Chapter 1, negligence offences in French criminal law are *délits* or *contraventions* and not *crimes*, and therefore not punishable by life imprisonment as it may be the case in England for GNM. This may impact on the use of criminal law in healthcare malpractice because judges are perhaps more willing to convict for less serious offences than for *crimes* as there is less stigma attached to a conviction for a more minor offence than a conviction for a serious offence. A conviction for GNM could be more devastating than *homicide involontaire* (involuntary manslaughter) especially for a doctor, also given the fact that in practice in France, most prison sentences are suspended sentences and those who are convicted of negligence offences in France rarely go to jail.<sup>41</sup> Thus, it is argued that ‘in France, it seems to be accepted that a proper judicial reaction to a negligent homicide or wounding is a fine, plus the stigma of a conviction and a ‘virtual’<sup>42</sup> prison sentence’.<sup>43</sup>

### 2.3.1 Individual Criminal Responsibility

In both countries, a fatal error could result in prosecutions for involuntary homicide. In France, this will be for *homicide involontaire*, the closest equivalent of GNM. However, in France, non-fatal errors may also result in prosecutions for negligence offences and a simple error is usually sufficient for a prosecution

<sup>41</sup> JR Spencer, MA Brajeux, above n26 at 22; Sénat, Les délits non intentionnels-La Loi Fauchon: 5 ans après-Actes du colloque, 1er mars 2006, Palais du Luxembourg, 48.

<sup>42</sup> ‘Virtual’ is used here as a synonym of ‘suspended’.

<sup>43</sup> JR Spencer, MA Brajeux, above n26 at 22.

when the causal link was direct. This section will show that English criminal law contains broad equivalents to French negligence offences but they are not used in the healthcare malpractice context.

Contrary to GNM, *homicide involontaire* only requires proof of simple negligence when the causal link is direct. *Homicide involontaire* is defined as ‘the fact of causing, in the conditions and according to the distinctions laid down by article 121-3, by ineptitude, carelessness, inattention, negligence or a breach of an obligation of security or of care imposed by legislation or regulation, the death of another’.<sup>44</sup> In theory, in the case of *homicide involontaire*, a doctor may be sentenced 3 years in prison and fined 45000 Euros.<sup>45</sup>

*Blessures involontaires* (involuntary wounding) appears to have no direct equivalent in English criminal law<sup>46</sup> but is considered an offence under the French *Code Pénal*.<sup>47</sup> It is defined as ‘the fact of causing, in the conditions and according to the distinctions laid down by article 121-3, by ineptitude, carelessness, inattention, negligence or a breach of an obligation of security or of care imposed by legislation or regulation, a total incapacity to work in excess of three months to another person’.<sup>48</sup> The closest equivalent found in English criminal law is ‘unlawfully or maliciously wounding or causing grievous bodily harm’ from section 20 of the Offences Against the Person Act 1861 (OAPA 1861).<sup>49</sup> Intent to harm is not required to be proven; only recklessness is required to be proven.<sup>50</sup> Section 20 might apply to serious cases of healthcare malpractice in England. However, it has not yet been used in England against doctors for malpractice whereas, it will be shown later, *blessures involontaires* is an offence charged in the context of healthcare malpractice.

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<sup>44</sup> Art 221-6 CP.

<sup>45</sup> Ibid; In Chapter 3, the criminal law and criminal process in the context of negligence as well as sentences used in cases of negligence in England will be analysed as comparison with the French system.

<sup>46</sup> M Brazier, A Alghrani, ‘Fatal Medical Malpractice and Criminal Liability’ (2009) 25(2) *Journal of Professional Negligence*, 51-67.

<sup>47</sup> Art 121-3 CP; Offences Against the Persons Act 1861 s 18, s 20.

<sup>48</sup> Art 222-19 al 1 CP; art R625-2 CP; In the case of *blessures involontaires*, the sentence will depend on how long the victim was unable to work after she was injured. The term used in the CP is *incapacité totale de travail* (literally, ‘incapacity to work’). When the *incapacité totale de travail* (ITT) lasts longer than 3 months, *blessures involontaires* are considered a *délit* and may be punished 2 years in prison and fined 30000 Euros. When the ITT is less than 3 months, the offence of *blessures involontaires* is considered a *contravention* and is only fined.

<sup>49</sup> Offences Against the Person Act 1861 s 20.

<sup>50</sup> *R v Mowatt* [1968] 1 QB 421; *R v Savage and Parmenter* [1992] AC 699 (HL); A Ashworth, above n34 at 300-302.

A third offence which seems to be used against negligent medical professionals or officials in France is *non-assistance à personne en danger* (failure to assist a person in danger).<sup>51</sup> It is committed by ‘anyone who, being able to prevent by immediate action a *crime* or a *délit* against the bodily integrity of a person, without risk to himself or to third parties, wilfully abstains from doing so [...] The same penalties apply to anyone who wilfully fails to offer assistance to a person in danger which he could himself provide without risk to himself or to third parties, or by initiating rescue operations’.<sup>52</sup> A breach of the Good Samaritan law is subject to a maximum sentence of 5 years in prison and fined 75000 Euros, which we may note, is higher than for *homicide involontaire* (3 years). This shows the importance of the duty to rescue in French criminal law. English criminal law does not recognise the failure to rescue as a criminal offence. Only the offence of wilful neglect/ill-treatment of mental health patients from section 127 of the Mental Health Act 1983 (MHA 1983) and section 44 of the Mental Capacity Act 2005 (MCA 2005) is applicable in the healthcare context.<sup>53</sup> Contrary to *non-assistance à personne en danger*, the offence of ‘ill-treat or wilfully neglect’ only applies to patients already receiving care under the MHA 1983 or patients who lack mental capacity.<sup>54</sup> This could take into account neglect of patients who were unconscious or anaesthetised when the harm was caused but does not do so in practice. So far, prosecutions for wilful neglect seem to be limited to charges for abusive conduct of staff or managers working in care homes for the elderly or learning disabled.<sup>55</sup> I will demonstrate later that the recognition of the failure to rescue in French criminal law goes a long way towards explaining the greater scope for criminalisation of healthcare malpractice, in particular in the HIV-contaminated blood episode where two doctors were convicted of this offence in France. I shall later discuss whether wilful neglect could and should be extended to all NHS patients.<sup>56</sup>

Two cases seem to illustrate the fact that *non-assistance à personne en danger* in French criminal law facilitates the prosecution of doctors in that area. In France, a surgeon had proceeded to a non-essential examination during surgery on a high

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<sup>51</sup> M Daury-Fauveau, above n10 at 26-27.

<sup>52</sup> Art 223-6 CP.

<sup>53</sup> MCA 2005 s 44; MHA 1983 s 127.

<sup>54</sup> N Allen, ‘Psychiatric Care and Criminal Prosecution’ in D Griffiths and A Sanders (eds), *Medicine, Crime and Society* (Cambridge University Forthcoming 2013) 159.

<sup>55</sup> Ibid 160.

<sup>56</sup> See Ch7 pt7.2.4, 210.

risk patient who had just fallen into a coma. The surgeon was charged with *non-assistance à personne en danger*.<sup>57</sup> In England, a surgeon had undertaken an unnecessary operation on a pre-operative risk patient and had failed to treat her appropriately when she suffered a cardiac arrest during surgery. He could not be charged with GNM because the CPS considered that there was no causal link between the conduct of the doctor and the death of the patient.<sup>58</sup> In France, the surgeon could have been convicted of *non-assistance à personne en danger* regardless of causation.

*Mise en danger délibérée d'autrui* (deliberately putting someone in danger) is another offence used in the context of healthcare malpractice in France. Article 223-1 provides that 'the direct exposure of another person to an immediate risk of death or injury likely to cause mutilation or permanent disability by the manifestly deliberate violation of a specific obligation of safety or prudence imposed by any statute or regulation is punished by one year's imprisonment and a fine of €15,000'.<sup>59</sup> It applies when the negligence is a *faute délibérée* (a form of recklessness). *Mise en danger délibérée* may be used as a free-standing criminal offence or as an aggravating circumstance of other criminal offences. The French Parliament wanted to criminalise behaviour which showed disregard to another by creating the concept of *faute délibérée*.<sup>60</sup> Offences which have the mens rea of *mise en danger délibérée d'autrui* are treated as aggravated offences of negligence with a higher sentence. For instance, in the case of *homicide involontaire* aggravated by *mise en danger délibérée*, the sentence increases from three to five years imprisonment.<sup>61</sup> As an offence on its own, it is defined as 'directly exposing another to an immediate risk of death or injury leading to a mutilation or permanent infirmity by the manifestly deliberate violation to a particular obligation of security or care imposed by the law'.<sup>62</sup> The offence arises whether or not any harm was actually caused by the deliberate risk taking.<sup>63</sup> It is the only offence in French criminal law punishable by imprisonment that does not need to result in harm. A year after the new *Code Pénal* came into force, there had been over hundred convictions for this offence, a majority of which

<sup>57</sup> Crim. 3 décembre 1997, Chabert, Resp civ et ass 1998, n° 251.

<sup>58</sup> D Griffiths, A Sanders, above n9 at 13.

<sup>59</sup> Art 223-1 CP.

<sup>60</sup> M Daury-Fauveau, above n10 at 26-27.

<sup>61</sup> Art 221-6 CP.

<sup>62</sup> Art 223-1 CP.

<sup>63</sup> Sénat, above n41 at 8.

were against car drivers.<sup>64</sup> Prosecutions for *mise en danger délibérée* on its own are rarely recorded, but it is said to be widely used in the field of healthcare malpractice as an aggravated circumstance of *homicide involontaire* and *blessures involontaires*.<sup>65</sup>

For example, an anaesthetist was convicted of *blessures involontaires* aggravated with *mise en danger délibérée*, when he had used the same bottle of product and only two syringes for six different patients, without consulting the patients prior to the anaesthesia, and had failed to examine them or control the effect of the anaesthesia after the surgery.<sup>66</sup> The doctor's behaviour was different from mere negligence or carelessness. It was considered to be obvious selfishness.<sup>67</sup> The closest English equivalent to *mise en danger délibérée* seems to be wilful neglect/ill-treatment. *Mise en danger délibérée* requires proof of recklessness but once again, applies to all cases of healthcare malpractice.

A category of offences that might be considered close to negligence *délits* are health and safety offences in England provided by the Health and Safety at Work Act 1974 (HSWA 1974). Offences contained in this Act resemble the regulatory nature of offences applied in the context of healthcare malpractice in France. Under this Act, the Health and Safety Executive (HSE) can in theory prosecute individual healthcare practitioners but it has not at present done so. An employee at work who fails 'to take reasonable care for the health and safety of himself and of other persons who may be affected by his acts or omissions at work' is criminally liable under section 7 of the HSWA 1974.<sup>68</sup> However, the HSE does not prosecute matters relating to quality of care or clinical judgement, which excludes a great number of cases of healthcare malpractice from criminalisation under the Act.<sup>69</sup>

Thus, currently only causing death by gross negligence is likely to be criminalised in England in the context of healthcare malpractice. English criminal law however contains offences which potentially could apply to cases of healthcare malpractice where injury has been caused. I will discuss in Chapter 7

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<sup>64</sup> C Elliott, *French Criminal Law* (Willan 2001) 80-81.

<sup>65</sup> M Daury-Fauveau, above n10 at 29.

<sup>66</sup> Crim. 11 Septembre 2001, Bull N°176.

<sup>67</sup> Ibid.

<sup>68</sup> HSWA 1974 s 7(a), s 33(1)(a).

<sup>69</sup> See <<http://www.hse.gov.uk/healthservices/arrangements.htm>>.

whether these offences should at all apply to cases of healthcare malpractice (causing GBH) or should be extended to all cases of healthcare malpractice which resulted in injury (wilful neglect) but I will argue against the criminalisation of simple negligence in the context of healthcare malpractice as it is in France. As will be shown later in the thesis, the HSWA 1974 has been used to prosecute Trusts and recent developments regarding corporate homicide have prompted the question of whether corporate offences could be used in the healthcare context.

### 2.3.2 Corporate Criminal Responsibility

The Institute of Medicine's report *To Err is Human* and the Department of Health's report *Organisation with a Memory* emphasised the fact that most healthcare errors were not in general the result of individual healthcare malpractice but were the results of disorganisation of health services.<sup>70</sup> As an example, Mr Jowett, a patient diagnosed with leukaemia was prepared to receive an injection of vincristine as part of his treatment.<sup>71</sup> A senior house officer injected the drug intrathecally instead of intravenously and this was fatal for the patient.<sup>72</sup> The doctor pleaded guilty and was sentenced to 8 months in prison for the killing of Mr Jowett.<sup>73</sup> An inquiry was conducted and found that 'the adverse incident that led to Mr Jowett's death was not caused by one or even several human errors but by a far more complex amalgam of human, organisational, technical and social interactions'.<sup>74</sup> It is worth noting that this case and many others happened after, and despite, a very publicised case of healthcare malpractice where two doctors (Drs Prentice and Sullman) were acquitted on appeal for GNM because their failure was a result of a failure in the service.<sup>75</sup>

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<sup>70</sup> L Kohn, J Corrigan and M Donaldson (eds), *To Err is Human: Building a Safer Health System* (Washington: National Academy Press 1999); Department of Health, *An Organisation with a Memory: Report of an Expert Group on Learning from Adverse Events in the NHS chaired by the Chief Medical Officer* (London: HMSO 2000); O Quick, 'Medical Manslaughter: The Rise (and Replacement) of a Contested Crime?', in C Erin, S Ost (eds), *The Criminal Justice System and Health Care* (Oxford University Press 2007) 35-36; N Allen, 'Medical or Managerial Manslaughter', in C Erin, S Ost (eds), *The Criminal Justice System and Health Care* (Oxford University Press 2007) 49.

<sup>71</sup> B Toft, *External Inquiry into the adverse incident that occurred at Queen's Medical Centre, Nottingham* (Department of Health, 4<sup>th</sup> January 2001) 9.

<sup>72</sup> Ibid.

<sup>73</sup> Unknown author, 'Anger as fatal jab doctor freed', *BBC News*, 23 September 2003.

<sup>74</sup> B Toft, above n71 at 40.

<sup>75</sup> See ch2, pt2.4.

This suggests that healthcare systems do not learn from error as much as they should or the criminal process is insufficient in ensuring prevention and this shows the importance of corporate error in the context of healthcare malpractice. However, the question of whether corporate offences should at all be used to criminalise health institutions for malpractice will be later debated in Chapter 8 and I will argue that corporate criminal responsibility is not necessarily the answer to corporate healthcare malpractice.

In both France and England, corporations may be criminalised for malpractice but again, French criminal law offers a wider range of corporate offences than English criminal law. Since 1994, the French *Code Pénal* provides that corporations, apart from the State, can be criminally liable in the conditions set out in the Code for individuals.<sup>76</sup> Thus, in France, a hospital may be prosecuted for any of the criminal offences which apply to individuals ie *blessures involontaires*, *homicide involontaire*, *non-assistance à personne en danger* or *mise en danger délibérée* in a criminal court in addition to possible convictions of individual health professionals.<sup>77</sup> Even if the directing body or member of the organisation is not found guilty, the corporation may still be convicted.<sup>78</sup> For instance, in 2003, the *tribunal correctionnel* of Paris convicted a hospital for *mise en danger délibérée d'autrui* and *homicide involontaire* for failings in the service which caused the death of a child.<sup>79</sup> The child presented at the emergency room of the hospital with severe gastroenteritis and vomiting. He could not be admitted to the gastroenterology service as there were no beds available. He was admitted to the pneumology service. One *interne* (training doctor), one nurse on duty and one nursery nurse looked after the child in the two days following his arrival at the hospital. On the second day, the nursery nurse noticed that the drip had stopped working and informed the nurse on duty who asked the *interne* for instructions. The *interne* ordered that the drip should be stopped but did not check on the child and left the service without giving any other recommendations to the other nurses. The mother of the child later noticed that the child was shaking and his stools were quite abundant, she informed the three other nurses who also left the service during the night. The child was transferred to intensive care the next morning and died a few days later. Nurses, doctors and the director

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<sup>76</sup> Art 121-2 CP.

<sup>77</sup> Art 121-2 CP.

<sup>78</sup> CA Grenoble, 12 juin 1998, affaire du Drac.

<sup>79</sup> TGI de Paris, 16<sup>e</sup> Chambre, jugement du 3 septembre 2003, affaire n° 9926423046.



of the hospital were convicted of *homicide involontaire* and *mise en danger délibérée* through breach of an obligation of security or care, particularly the breach of a regulation<sup>80</sup> which imposed that nursing staff and hospital directors make sure that tasks are shared by nurses and nursing auxiliaries, as well as a circular<sup>81</sup> which provided that hospital staff could not expose very young patients to an immediate risk of death or serious wounding.<sup>82</sup>

Contrary to individual negligence offences, the new rules on causation contained in the *Loi Fauchon* do not apply to corporations. If the causal link between the corporation's negligence and the damage is indirect, it does not have to be a *faute caractérisée* (a form of gross negligence).<sup>83</sup> Thus, the provision of the *Code Pénal* for negligence committed by corporations provide for an even wider scope for the criminalisation of healthcare malpractice.

In England, before the Corporate Manslaughter and Corporate Homicide Act 2007 (CMCH 2007) came into force in 2008, corporations could be criminally liable for manslaughter using either direct corporate liability, vicarious liability which applied in several contexts including health and safety at work<sup>84</sup>, or using the identification doctrine.<sup>85</sup> According to the doctrine of vicarious liability, senior managers were criminally liable only for certain offences for the acts of their employees.<sup>86</sup> The identification principle required that when the directing mind of the corporation was culpable, then the corporation itself would be culpable which was very difficult to prove.<sup>87</sup> Since 2008, English criminal law includes the criminalisation of corporations for GNM under the CMCH 2007. The Act provides that a corporation is criminally liable 'if the way in which its activities are managed or organised (a) causes a person's death and (b) amounts to a gross breach of a relevant duty of care owed by the organisation to the

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<sup>80</sup> Décret n° 93-345 du 15 mars 1993 relatif aux actes professionnels et à l'exercice de la profession d'infirmier, JORF n° 63 du 15 mars 1993, 4098.

<sup>81</sup> Circulaire DGS/PS3/DH/PH1 N° 9631 du 19 janvier 1996 relative au rôle et aux missions des aides-soignants et des auxiliaires de puériculture dans les établissements hospitaliers.

<sup>82</sup> TGI de Paris, above n79.

<sup>83</sup> Assemblée Nationale, above n21 at 37; Y Mayaud, *Violences involontaires et responsabilité pénale* (Dalloz Référence 2003) 206.

<sup>84</sup> HSWA 1974 s 3.

<sup>85</sup> N Allen, 'Medical or Managerial manslaughter', above n70 at 60-62; CMV Clarkson, HM Keating, SR Cunningham, *Criminal law* (7<sup>th</sup> edn, Thompson Sweet and Maxwell 2010) 243-247; *Tesco Supermarket Ltd v Natrass* [1972] AC 153.

<sup>86</sup> J Gobert, 'Corporate Criminality: Four model of fault' (1994) 14(3) *Legal studies* 393, 396.

<sup>87</sup> N Allen, 'Medical or Managerial Manslaughter', above n70 at 56.

deceased’.<sup>88</sup> The criminalisation under the CMCH 2007 affects health institutions but also admit a large range of exceptions in the healthcare context as will be demonstrated in Chapter 8.<sup>89</sup>

Healthcare services, including Primary Care Trusts, Hospital Trusts, Mental Care Services and Ambulance Service Trusts are criminally liable under the HSWA 1974 for exposing their employees or other persons (ie patients and members of the public) to ‘risks to their health or safety’.<sup>90</sup> For example, an NHS Trust was fined £100,000 by the HSE for failing to monitor doctors properly and spot mistakes.<sup>91</sup> Similarly, the Southampton University Hospital Trust was fined £100,000 following the conviction of Drs Misra and Srivastava for gross negligence.<sup>92</sup> However, as explained earlier, current HSE policy does not admit the application of the HSWA 1974 to cases of clinical judgment or quality of care.

Once again, the conditions for criminalising are much more limited in English criminal law. In England, corporations may only be criminalised for causing a person’s death by ‘gross breach of a relevant duty of care owed by the organisation to the deceased’ and for exposing someone to a risk to his health and safety when the event was not a result of clinical judgment or quality of care.<sup>93</sup>

In England, the HSWA 1974 seems to be used more often than corporate manslaughter even in the context of healthcare malpractice.<sup>94</sup> The CMCH 2007 has been in force for four years now and no NHS trusts have yet been prosecuted for corporate manslaughter for the death of a patient as a result of medical treatment.<sup>95</sup> Wells points out that the CMCH 2007 is ‘complex and the offence definition itself is full of ambiguities and interpretive uncertainty’.<sup>96</sup> However,

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<sup>88</sup> CMCH 2007 s 1(1).

<sup>89</sup> See ch8 pt 8.3.1, 242.

<sup>90</sup> HSWA 1974 s 2, s 3; C Wells, ‘Medical Manslaughter-Organisational Liability’ in D Griffiths and A Sanders (eds), *Medicine, Crime and Society* (Cambridge University Press Forthcoming 2013) 202.

<sup>91</sup> See <<http://www.healthandsafetyatwork.com/hsw/content/nhs-trust-fined-%C2%A3100,000-for-poor-supervision>>.

<sup>92</sup> *R v Southampton University Hospital NHS Trust* [2006] EWCA Crim 2971; ‘Hospital trust fined £100k for knee op death’, *Mail Online*, 11 April 2006.

<sup>93</sup> CMCH 2007 s 1(1).

<sup>94</sup> O Quick, ‘Medical Manslaughter: The Rise (and Replacement) of a Contested Crime?’, above n70 at 40.

<sup>95</sup> C Wells, above n90 at 200.

<sup>96</sup> *Ibid.*

currently, ‘prosecutions against health care providers for breaches under [section 3(1) of the HSWA 1974] are very unusual, and certainly less prevalent than manslaughter prosecutions against individual practitioners’.<sup>97</sup>

Thus, once again, French substantive criminal law admits a greater scope for the criminalisation of health institutions for negligence than English criminal law. In Chapter 8, I will argue that as for individual healthcare malpractice, a wider criminalisation of corporate healthcare malpractice is not always desirable but the focus should rather be put on senior managers and effective means to ensure healthcare safety should be considered.

## **2.4 Types of Healthcare Malpractice Cases Criminalised in France and England**

In France and England, the conditions for the criminalisation of negligent conduct with regard to the level of moral culpability and causation show differences which affect the way criminal law is used in the context of healthcare malpractice. In France, simple negligence may be criminalised whereas in England, only gross negligence is criminalised. The French *Code Pénal* includes a greater number of *fautes* than English criminal law. French criminal law takes into account different levels of moral culpability, from simple negligence to recklessness. Consequently, in the context of healthcare malpractice, a greater number of *fautes* are criminalised, extending to errors that might at most be clinical negligence and subject to a civil claim in England.<sup>98</sup> Looking at French case law, types of cases of healthcare malpractice which the *Code Pénal* has been applied to with regard to negligent conduct include negligent diagnosis, technical negligence, negligent supervision or organisation whether they are *faute simple*, *faute caractérisée* or *faute délibérée*.<sup>99</sup>

A *faute simple* in French law includes conduct of ‘ineptitude, carelessness, inattention, negligence or a breach of an obligation of security or of care imposed by legislation or regulation’.<sup>100</sup> Thus, an obstetrician was criminally liable for

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<sup>97</sup> O Quick, ‘Medical Manslaughter: The Rise (and Replacement) of a Contested Crime?’, above n70 at 40.

<sup>98</sup> JR Spencer, MA Brajeux, above n26 at 16.

<sup>99</sup> M Daury-Fauveau, above n10 at 26-27.

<sup>100</sup> Art 221-6 CP.

using forceps when it was not necessary and a surgeon was criminally liable for removing the right kidney instead of the left kidney.<sup>101</sup> In England, two doctors were cleared of manslaughter even though they had removed the wrong kidney from a patient because it could not be proven that the error led to the death.<sup>102</sup>

*Faute caractérisée* is broadly the equivalent of the English gross negligence.<sup>103</sup> It is defined as ‘exposing another person to a particularly serious risk of which they ought to have been aware’.<sup>104</sup> One commits a *faute caractérisée* when he does not seek to cause damage but is indifferent to the damage, when his conduct amounts to gross carelessness or negligence that a sensible professional would not commit<sup>105</sup>, or ‘a series of negligent and careless conducts which each has a certain causal link with the damage, and that the accumulation permits to establish the negligence [...] of particular gravity of which consequences could have not been ignored’.<sup>106</sup>

Since 2000, in theory *faute caractérisée* is required when the negligence resulted from an indirect causal link.<sup>107</sup> To establish the knowledge of a risk, French courts either look at whether the behaviour of the doctor shows that he considered the foreseeable risks<sup>108</sup> or sometimes simply presume that the doctor was aware of the risk.<sup>109</sup> In the following example, an anaesthetist was convicted of *homicide involontaire* with *faute caractérisée*. The courts considered that he had not given sufficient instructions to nurses with regard to monitoring the condition of a child who was bleeding profusely following a tonsillectomy. He was considered to have underestimated the scope of the haemorrhage and contributed to the death of the patient, who died of a cardiac arrest during the anaesthesia and further treatment.<sup>110</sup>

A *faute délibérée* is defined in the *Code Pénal* as the *mise en danger délibérée d'autrui* (see 2.3.1). It is close to what Merry and McCall Smith would define as

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<sup>101</sup> M Daury-Fauveau, above n10 at 26-27.

<sup>102</sup> R Alleyne, ‘Surgeons who removed the wrong kidney are cleared’, *The Telegraph*, 26 June 2002.

<sup>103</sup> Although, the definitions of *faute caractérisée* and gross negligence are somewhat different.

<sup>104</sup> Art 121-3 al 4 CP.

<sup>105</sup> VD Commaret, *La Loi Fauchon, 5 ans après* (2006) Chron. N7, spec. N18 *Droit Pénal*.

<sup>106</sup> Crim. 10 janv. 2006, n° 04-86.428; B Cotte et D Guihal, *La Loi Fauchon, 5 ans de mise en oeuvre jurisprudentielle* (2006) chron. N6, et spéc. N44 *Droit Pénal*; B Boulloc, H Matsopoulou, *Droit pénal général et procédure pénale* (18<sup>e</sup> edn, Sirey 2011) 105-106.

<sup>107</sup> Art 121-3 CP.

<sup>108</sup> Crim. 18 juin 2002, Bull. Crim., no 138.

<sup>109</sup> Crim. 24 septembre 2003, no 02-81.820, inédit.

<sup>110</sup> Crim. 13 février 2007, no 06-82.202 Bull. Crim. 2007 n° 44, 261.

violations ie deliberate risk taking. It is an aggravating circumstance of negligence offences and also a free-standing criminal offence as explained earlier in the chapter.<sup>111</sup> *Faute délibérée* is committed when one has ‘broken a duty of care or precaution laid down by statute or regulation in a manifestly deliberate manner’.<sup>112</sup>

In England, criminal law is normally only used against healthcare professionals when their negligence was gross and caused the death of the patient. Contrary to how French *fautes* have been defined, defining gross negligence in English criminal law has proved difficult. Until *Adomako*<sup>113</sup> in 1995, English courts admitted involuntary manslaughter by gross negligence and by recklessness.<sup>114</sup> Courts had identified two types of recklessness: *Cunningham*<sup>115</sup> recklessness and *Caldwell*<sup>116</sup> recklessness (which has since been rejected).<sup>117</sup> According to *Cunningham*, a person was reckless if he knew that there was a risk that harm might occur but nevertheless took that risk. *Caldwell* went further in the sense that a defendant was reckless if ‘he [did] an act which [...] [created] an obvious risk’, and ‘he either [had] not given any thought to the possibility of there being any such risk or [had] recognised that there was some risk involved and [had] nonetheless gone on to do it’.<sup>118</sup> Since 1995, gross negligence alone would be enough to establish culpability for involuntary manslaughter.

However, currently, the definition of what makes negligence ‘gross’ for the purpose of a prosecution for GNM in English criminal law is considered rather vague and circular which increases the gap between French and English criminal law in the healthcare malpractice context as it leaves room for prosecutorial discretion and may contribute to the reluctance to prosecute doctors.<sup>119</sup> Looking at three leading cases may help.

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<sup>111</sup> Art 223-1 CP.

<sup>112</sup> Art 223-1 CP.

<sup>113</sup> *R v Adomako* [1995] 1 AC 1. But from 1986, it was thought that GNM had been ‘absorbed into and replaced by reckless manslaughter’. A Ashworth, above n34 at 277.

<sup>114</sup> A Ashworth, above n34 at 276-277.

<sup>115</sup> *R v Cunningham* [1957] 2 QB 396.

<sup>116</sup> *R v Caldwell* [1982] AC 341 (HL).

<sup>117</sup> C Elliott, ‘Recent Developments in the English Law of Involuntary Manslaughter’ (1995) 272 *European Journal of Crime, Criminal Law, and Criminal Justice*; CMV Clarkson, HM Keating, SR Cunningham, above n85 at 158-162.

<sup>118</sup> [1982] AC 341 (HL).

<sup>119</sup> O Quick, ‘Medicine, mistakes and manslaughter: a criminal combination?’ (2010) 69(1) *Cambridge Law Journal* 186, 193.

In *Sullman and Prentice*<sup>120</sup>, two junior doctors had failed to check the labels before injecting cytotoxic drugs into the patient's spine. The patient died. It appeared that neither defendant had previously had significant experience with cytotoxic drugs.<sup>121</sup> The two doctors were initially convicted of GNM.<sup>122</sup> In *Adomako*<sup>123</sup>, a locum anaesthetist (Dr Adomako), during a minor eye operation, had failed to notice that a tube from the ventilator which carried oxygen to the patient was disconnected, although the patient had ceased to breathe. As a consequence, the patient died from cardiac arrest.<sup>124</sup> It was said that 'the standard of care that the patient [had] received was abysmal'.<sup>125</sup> Evidence was brought to the court that the defendant had shown 'gross dereliction of care'.<sup>126</sup> The doctor was also convicted of GNM.<sup>127</sup>

All three doctors appealed and the appeals were heard together in the Court of Appeal.<sup>128</sup> In the Court of Appeal<sup>129</sup>, it was held that three matters needed to be proved in order to convict for GNM: '(1) the existence of the duty; (2) a breach of the duty causing death; (3) gross negligence which the jury considered justified a criminal conviction'.<sup>130</sup> It is this last condition that has proved problematic. At least one of the following criteria had to be fulfilled to lead to a conviction for GNM:

- (1) indifference to an obvious risk of injury to health;
- (2) actual foresight of the risk coupled with the determination nevertheless to run it;
- (3) an appreciation of the risk coupled with the intention to avoid it but with such a high degree of negligence in the attempted avoidance that the jury considered it justified conviction;

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<sup>120</sup> *R v Prentice; R v Sullman* [1994] QB 302.

<sup>121</sup> *R v Prentice; R v Sullman* [1993] 4 All ER 935 at 945-947.

<sup>122</sup> *Ibid* 938.

<sup>123</sup> *R v Adomako* [1995] 1 AC 1.

<sup>124</sup> [1993] 4 All ER 935 at 951.

<sup>125</sup> *Ibid* 952.

<sup>126</sup> *Ibid*.

<sup>127</sup> *Ibid* 938-939.

<sup>128</sup> *Ibid* 935.

<sup>129</sup> *Ibid*.

<sup>130</sup> *Ibid* 936.

(4) inattention or failure to advert to a serious risk which went beyond ‘mere inadvertence’ in respect of an obvious and important matter which the defendant’s duty demanded the jury should address.<sup>131</sup>

Prentice’s and Sullman’s appeals succeeded as the Court of Appeal considered that the jury had been misdirected by the trial judge. Hypothetically, if Drs Sullman and Prentice had been judged in France, they could have possibly been convicted of *homicide involontaire* because they would have committed a *faute simple* and would be in a direct causal link with the damage. Adomako’s appeal failed. He then appealed to the House of Lords but his appeal was dismissed because the court considered that he had committed gross negligence.<sup>132</sup> The House of Lords held that

Whether the defendant's breach of duty amounted to gross negligence depended on the seriousness of the breach of duty committed by the defendant in all the circumstances in which he was placed when it occurred and whether, having regard to the risk of death involved, the conduct of the defendant was so bad in all the circumstances as to amount in the jury's judgment to a criminal act or omission.<sup>133</sup>

In *R v Misra & Srivastava*, two junior doctors who worked at the Southampton General Hospital had failed to diagnose a post-operative infection on a patient who had undergone surgery to treat his patella tendon. The infection was left untreated for two days as the two doctors ‘entirely disregarded’ the results of blood tests which could have given indications on the infection, even though the patient showed obvious signs of infection.<sup>134</sup> As a result, the patient died of toxic shock.<sup>135</sup> It was said that ‘the quality of the care provided by the doctors ‘did not even begin to approach the standard to be expected of them’’.<sup>136</sup> Drs Misra and Srivastava were convicted of GNM and sentenced to 18 months imprisonment suspended for 2 years. The two doctors then appealed the decision on the grounds that the test on gross negligence was circular and consequently involved

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<sup>131</sup> Ibid 936-937, 944; The impact of the jury on criminal proceedings involving healthcare professionals prosecuted for GNM is analysed in ch3 pt3.6, 84.

<sup>132</sup> [1994] 3 All ER 79 at 80.

<sup>133</sup> Ibid.

<sup>134</sup> *R v Misra ; R v Srivastava* [2004] EWCA Crim 2375.

<sup>135</sup> Ibid.

<sup>136</sup> Ibid.

uncertainty, contrary to article 7 of the European Convention of Human Rights (ECHR). The Court of Appeal held that the *Adomako* test on gross negligence involved ‘no uncertainty’ and did not violate the ECHR.<sup>137</sup> Drs Misra and Srivastava’s appeal was dismissed.<sup>138</sup> Therefore, the same test was applied in all three cases.

Tadros has noted that the offence of manslaughter is very broad and thus may include defendants with different levels of blameworthiness.<sup>139</sup> The current test of gross negligence is unclear and leaves great scope for interpretation and depends on the jury’s judgement on what is criminal. The judge who sentenced Drs Prentice and Sullman told them: ‘you could have been helped more than you were helped-you are far from being bad men’.<sup>140</sup> On the other hand, Dr Adomako’s standard of care was said to be appalling and Drs Misra and Srivastava were consistently ‘grossly’ negligent over a long period of time. Quick argued that ‘the idea that the offence ingredients involve no uncertainty is at best unrealistic and at worst disingenuous’.<sup>141</sup> The current test of gross negligence does not seem to achieve a consistent criminalisation of healthcare malpractice and needs to be made clearer or the threshold for criminal liability should be altered and linked to subjective fault.

The definition of criminal negligence in French law is clearer than in English law and thus limits the scope for inconsistencies in application apparent in the current test of gross negligence in English law. The French definition admits conduct amounting to simple negligence as being criminal, whereas the English test of gross negligence leaves to the jury the determination of what should be criminal, and it will be shown in Chapter 3 that juries are perceived as usually reluctant to convict doctors for GNM. Thus, the gross test is rather circular contrary to *faute caractérisée* which has a much clearer definition in French criminal law which allow the courts to have an extensive approach to what *faute caractérisée* is in the context of healthcare malpractice in France.

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<sup>137</sup> *R v Misra & Srivastava* [2005] 1 Cr App R 328.

<sup>138</sup> [2004] EWCA Crim 2375.

<sup>139</sup> V Tadros, ‘The Limits of Manslaughter’, in CMV Clarkson, S Cunningham (eds), *Criminal Liability for Non-Aggressive Death* (Ashgate 2008) 42.

<sup>140</sup> [1994] QB 302.

<sup>141</sup> O Quick, ‘Expert Evidence and Medical Manslaughter: Vagueness in Action’ (2011) 38 (4) *Journal of Law and Society* 496, 500.



Currently, English criminal law in relation to negligent conduct provides a greater scope for moral luck than does French law.<sup>142</sup> As mentioned earlier, a doctor's mistake might be terrible, if it did not cause the death of the patient, the doctor would not be prosecuted in England. This inconsistency has led to calls to reform English criminal law of negligence.<sup>143</sup> Griffiths and Sanders have proposed a new offence of 'medical neglect endangering life'.<sup>144</sup> Quick argues that there should be a 'stiffer test of subjective recklessness'.<sup>145</sup> The need for reform in that part of English criminal law in both the individual and the corporate contexts will be discussed in chapters 7 and 8 of this thesis. It is also argued that GNM as defined by the courts may leave great discretion to the CPS and juries in their decision to prosecute and convict when there is no evidence of subjective fault, as shall be demonstrated in the next chapter.<sup>146</sup>

## 2.5 Causation

Another crucial feature in the way France and England take a different view to the criminalisation of healthcare malpractice is causation. Even after the *Fauchon* reform, French criminal courts have an extensive approach to causation in the context of healthcare malpractice.

For a long time, French Courts used the *théorie de l'équivalence des conditions* which provided that when several events have caused the damage, each conduct which has contributed to the realisation of the harm is treated 'in isolation as a cause'.<sup>147</sup> This rule allowed greater scope for the criminalisation of negligence, as any person remotely related to the damage could be held liable for committing the 'lightest' *faute*.

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<sup>142</sup> M Kazarian, D Griffiths, M Brazier, 'Criminal responsibility for medical malpractice in France' (2011) 27 (4) *Journal of Professional Negligence*, 196.

<sup>143</sup> D Griffiths, A Sanders, above n9 at 153; O Quick, 'Medicine, Mistakes and manslaughter: a criminal combination?', above n115 at 199; V Tadros, above n139 at 49; CMV Clarkson, 'General Endangerment Offences: The Way Forward?' (2005) 32 *University of Western Australian Law Review* 131.

<sup>144</sup> D Griffiths, A Sanders, above n9 at 153.

<sup>145</sup> O Quick, 'Medical manslaughter and expert evidence: the role of context and character', in D Griffiths and A Sanders (eds), *Medicine, Crime and Society* (Cambridge University Press Forthcoming 2013) 109.

<sup>146</sup> O Quick, 'Medical Killing: Need for a Specific Offence?' in CMV Clarkson, S Cunningham (eds) *Criminal Liability for Non-Aggressive Death* (Ashgate 2008) 160-161.

<sup>147</sup> JR Spencer, MA Brajeux, above n26 at 12; Assemblée Nationale, above n21 at 18.

Since the *Loi Fauchon*, courts have to apply the *théorie de la causalité adéquate* which is stricter and takes into account the conduct which has the strongest causal link with the damage.<sup>148</sup> The *Loi Fauchon* provides that someone who has indirectly caused damage may be criminally liable only if his indirect negligence was *faute caractérisée* or *délibérée*.<sup>149</sup> This *loi* has limited the scope for criminalisation of negligence. As acknowledged in Chapter 1, the *Loi Fauchon* seems to be contextualised in terms of a move away from criminalisation.<sup>150</sup> The French Parliament wanted to restrict the courts' capacity to hold criminally liable people remotely related to the conduct in cases of *homicide involontaire* and *blessures involontaires*.<sup>151</sup> In the context of healthcare malpractice, a house officer could be criminally liable for injecting the wrong drug into a patient's artery (direct negligence). The senior doctor who fails to check that the injection was properly done by the house officer would be indirectly liable for the death or injury of the patient (depending on what the judge and experts consider to be a *faute caractérisée* or *faute délibérée*).<sup>152</sup> Thus, it seems that the senior doctor in *Prentice and Sullman* who could have supervised them would have been convicted in France for committing *faute caractérisée* as he had failed to prevent their negligence. Before the *Loi Fauchon* came into force, simple negligence would have been enough to convict him.

However, has the new *loi* actually limited the scope for criminalisation of negligence in practice? Spencer and Brajeux argue that the *Loi Fauchon* has not greatly affected the criminalisation of healthcare malpractice as French courts still seem to interpret causation in an extensive way.<sup>153</sup> French courts are ready to find a direct causal link even where an analysis of the link seems to suggest it is indirect.<sup>154</sup> For instance, a cosmetic surgeon had undertaken surgery on a 64 year-old patient who had a pre-existing medical condition.<sup>155</sup> The patient died of thrombosis. The surgeon was prosecuted and he argued that his negligence had

<sup>148</sup> Assemblée Nationale, above n21 at 18; JR Spencer, MA Brajeux, above n26 at 12.

<sup>149</sup> Art 121-3 CP.

<sup>150</sup> Sénat, above n41 at 7.

<sup>151</sup> B Boulloc, H Matsopoulou, above n106 at 105; Sénat, Session ordinaire de 1995-1996, Annexe au procès-verbal de la séance du 18 octobre 1995, N° 32, Proposition de loi relative à la responsabilité pénale des élus locaux pour des faits d'imprudence ou de négligence commis dans l'exercice des fonctions, Rapport.

<sup>152</sup> M Dauray-Fauveau, above n10 at 26-27.

<sup>153</sup> JR Spencer, MA Brajeux, above n26 at 16.

<sup>154</sup> See Crim. 10 février 2009, n° 08-80.679 Bull crim 2009, n° 33; Crim. 11 septembre 2012 n° 11-88.269.

<sup>155</sup> Crim. 29 octobre 2002, Bull n° 196, RSC 2003 chron. P 330, obs. Y. Mayaud.

only indirectly contributed to the damage. But judges held that his negligence had directly caused the victim to die and the surgeon was convicted of *homicide involontaire*.<sup>156</sup> Since the patient had a pre-existing condition that contributed to his death, the direct causal link between the doctor's negligence and the patient's death was not straightforward but French judges still admitted a direct causal link. In another example of the fact that French courts have a flexible approach to *faute caractérisée* and are willing to find *faute caractérisée* to criminalise doctors who were in an indirect causal link with the damage<sup>157</sup>, a doctor who specialised in endocrinology and gynaecology had failed to proceed to an urgent examination on a diabetic patient who died following a diabetic coma some days after the medical consultation. While the patient was showing alarming symptoms, the doctor, who had the means to do a first check on blood sugar rate, ordered blood tests without informing the laboratory that they were urgently needed. Judges in first instance held that the doctor was in a direct causal link with the death. The defendant appealed and the *Cour de Cassation* held that he was in an indirect causal link but had committed a *faute caractérisée*.<sup>158</sup>

One further example illustrates the point that even though French criminal law requires proof of 'gross' negligence when the causal link is indirect, the criminalisation of healthcare malpractice still has a large scope either by the court managing to find a direct link or a readiness to find *faute caractérisée*. A doctor (A) was found guilty of *blessures involontaires* when he had failed to proceed to a scan on a pregnant woman during the last prenatal examination, even though he was aware of the risks of a 'big' baby: notably an obese mother, the position in the uterus, and the fact that it was her second baby. The baby was born with a paralysed right arm because of a difficult delivery. The appeal court considered that there was a causal link between the harm and the doctor's intervention. The causal link between the harm and the doctor's intervention was though indirect because the aforesaid doctor was not the one who took care of the pregnant woman during labour, he was the one who was in charge of prenatal examinations. The *faute* committed by this doctor was indirect as the harm caused during labour/delivery was an indirect consequence of a failure in prenatal examination. The doctor had committed gross negligence and was in an

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<sup>156</sup> Ibid.

<sup>157</sup> See F. Rousseau, 'Le médecin face à la mort' (2012) *Actualité Juridique Pénal* 372.

<sup>158</sup> Crim. 12 septembre 2006, n° 05-86.700 (2006) *Actualité Juridique Pénal* 447.

indirect causal link with the damage so he was rightly convicted of  *blessures involontaires with faute caractérisée*.<sup>159</sup>

On the contrary, English criminal law always requires gross negligence that leads to death for criminal liability. And as we will see in the next chapter, the Crown Prosecution Service (CPS) tends to interpret that standard in a restrictive way, which narrows the scope of criminalisation of negligence even more.<sup>160</sup> In England, only a breach of duty that ‘caused or significantly contributed to the death’ would be criminalised, which would be the equivalent of a direct causal link in French criminal law, although in England that breach of duty would require proof of gross negligence to be criminalised.<sup>161</sup>

While French courts interpret causation in a broad sense, English prosecution authorities seem to be restrictive in their interpretation of a causal link. For instance, a surgeon had proceeded with a non-essential operation on a patient who was at serious pre-operative risk. He escaped prosecution, even though the patient suffered a cardiac arrest during the surgery.<sup>162</sup> Similarly, a midwife had committed serious omissions in the management of pre-labour and labour, notably the lack of treatment of worsening symptoms of the mother for two days. In both cases, prosecution was not considered feasible because experts could not establish causation.<sup>163</sup>

## 2.6 Conclusion

This chapter examined French and English substantive criminal law in relation to negligent conduct committed by health professionals and health institutions. Similarities and differences were analysed so as to find the factors responsible for the wider scope of the criminal law in France in the context of healthcare malpractice. Such comparative analysis revealed that French criminal law in the *Code Pénal* provides for a more general criminalisation of negligence than English common law, precedents and statutes. French criminal law contains a

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<sup>159</sup> Nancy, 29 mars 2001; Even though the decision was quashed by the *Cour de Cassation*, this shows that there is still a willingness to admit a large scope to causation from lower courts; Crim. 26 mars 2002 Inédit 01-83.416.

<sup>160</sup> See ch3 pt3.5, 82.

<sup>161</sup> [1995] 1 AC 1.

<sup>162</sup> D Griffiths, A Sanders, above n9 at 141.

<sup>163</sup> Ibid.

general definition of criminal negligence which might be used in holding health professionals and institutions to account whereas English criminal law includes a vague and circular definition of gross criminal negligence, which thus limits the scope for criminal prosecution of healthcare professionals. Most importantly, negligent conduct resulting in injury is criminalised in France whereas only GNM is at present criminalised in healthcare malpractice cases in England. The wider range of negligence offences in French criminal law permits readier criminalisation of health professionals and institutions, including cases of failure to act and omission to rescue, negligent wounding and deliberate conduct with no requirement of damage to result. However, English criminal law contains offences which could apply to cases of healthcare malpractice resulting in injury but they are not at present used. French negligence offences have a broader scope and may apply to all cases of negligent practice more generally. Convictions for negligence offences in France seem to have lesser stigma than a conviction for GNM in England. Negligence offences in French criminal law may only be punished by maximum five years imprisonment and suspended sentences are widely used, whereas in England, a conviction for GNM may result in life imprisonment, which is much more devastating for a doctor, although unlikely to happen. French substantive criminal law also provides for a wider range of corporate offences than English criminal law as they include all conduct which might be criminalised at the individual level. English law on the other hand only criminalises gross corporate manslaughter and corporate conduct which might result in injury in certain contexts. The rules on causation in French criminal law and their interpretation by the courts also provide with a greater scope for criminalising health professionals and institutions who have indirectly contributed to the damage. English criminal law only admits a direct causal link, which greatly limits the number of health professionals who could be held liable for having involuntarily caused the damage.

All these factors seem to explain why French criminal law has a greater scope in holding health professionals and health institutions to account for negligence. The question of whether England should look at France for a model on the criminalisation of doctors and health institutions will be discussed in Chapters 7 and 8. These chapters will focus on the need for more consistency of criminal negligence in English law, limiting the impact of moral luck in healthcare

malpractice episodes, widening the scope for criminalising malpractice resulting in injury short of death, and considering the more general question of whether criminal law should be used at all against negligent healthcare professionals, officials and institutions.

### **3. The Role of the Criminal Process in Regulating Healthcare Malpractice in France and England**

#### **3.1 Introduction**

In the previous chapter, I have shown that substantive criminal law has a significant impact on the way healthcare malpractice is criminalised in France and England. In France, simple negligence is criminalised when the causal link is direct and conduct resulting in injury short of death may also be a criminal offence, whereas in England only gross negligence manslaughter (GNM) has been used in the context of healthcare malpractice even though other offences are in theory available to criminalise conduct resulting in injury short of death in the healthcare malpractice context. Gross negligence has been ill-defined, whereas the definition of *faute caractérisée* in France when relevant, is clearer which may explain why a greater number of healthcare malpractice cases are prosecuted in France.

In this chapter, I address crucial differences in the criminal process itself and explore the very different procedural issues within the French inquisitorial system and the adversarial system in England to show the impact of these differences on prosecutions of doctors and health officials for malpractice. I suggest that the opposition between a state-based inquisitorial procedure and an adversarial procedure is a factor that influences the use of the criminal law in healthcare malpractice perhaps even more than substantive criminal law.

As mentioned in Chapter 1, fundamental differences in legal traditions of the two systems (inquisitorial and adversarial) seem to play a role in the criminalisation of healthcare malpractice. The French inquisitorial system is characterised by an emphasis on the pre-trial phase and pre-trial investigations conducted by a *juge d'instruction*<sup>1</sup> (JI) who has wide coercive powers to conduct investigations, and a strong involvement of victims in the pre-trial stage of the proceedings. In France, victims can join civil claims for compensation to criminal complaints and consequently launch criminal prosecutions. The English adversarial system, on the contrary, is more focused on the trial phase, characterised by the confrontation of two

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<sup>1</sup> Investigating judge.

equal parties with a jury deciding on the verdict, and where victims cannot launch criminal prosecutions or benefit from the evidence collected by a JI.

I argue that the involvement of victims at an early stage of the proceedings, the role of the JI and the absence of juries in criminal proceedings for negligence are major factors explaining the greater number of prosecutions leading to convictions of doctors and health officials in France for malpractice. This will be further developed in the more particular context of the HIV-contaminated blood episode in France and England, and will be used to explore the question of whether England should borrow some of the features of French criminal procedure to deal with healthcare malpractice. In particular, I will discuss the question of whether some of the ‘advantages’ of French criminal law in the context of healthcare malpractice ie involvement of victims in the proceedings and robust investigations of the facts could be achieved by other means than the criminal process in England to ensure healthcare safety and to respond to victims’ demands without reforming the whole of English criminal procedure.

### **3.2 The Impact of Different Systems of Criminal Procedure**

French criminal procedure and English criminal procedure are based on two distinct systems. The inquisitorial model (from Latin *inquisitio* which means ‘search’) underlies the intervention and supervision of an authority in the criminal proceedings which are directed to the ‘searching for the truth’<sup>2</sup>, which ‘will be as nearly objective as possible’, while the adversarial model underpins a confrontation between two equal parties (defendant(s) and victim(s)), ‘before a passive and impartial judge [and] a jury [...] pronouncing one version of events to be the truth’.<sup>3</sup> Thus, the French inquisitorial criminal process is focused on the pre-trial phase of the procedure which aims at ‘discovering the truth’<sup>4</sup>, involving ‘one central (judicial) figure representing

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<sup>2</sup> *Recherche de la vérité* (search for the truth) is a basic notion in French criminal law. It implies that the *Ministère Public* and the *juge d’instruction* work on finding the real facts of the case, by not being influenced by anyone’s testimony; R Van Ruymbeke, *Le juge d’instruction* (Presses Universitaires de France 2008) 36-37.

<sup>3</sup> N Jorg, S Field, C Brants, ‘Are Inquisitorial and Adversarial Systems Converging?’, in C Harding et al. (eds), *Criminal Justice in Europe: A Comparative Study* (Clarendon Press Oxford 1995) 42-43.

<sup>4</sup> However, we will see that trials in the *Tribunal correctionnel* involve adversarial elements.



the public interest [...] which might inculpate or exculpate any named suspect'<sup>5</sup>, whereas the English adversarial system is focused on the trial phase of the proceedings.<sup>6</sup> Even though both systems aim to protect society and punish wrongful conduct, French criminal procedure reflects a victim-oriented approach.<sup>7</sup> This is evidenced by the fact that victims of criminal offences in France have the right to join *constitutions de parties civiles*<sup>8</sup> to criminal complaints. As a consequence they launch the *Action Publique* (public prosecution) and are parties to the civil action in the proceedings. I will explain later that this partly explains the greater number of prosecutions for healthcare malpractice in France. On the contrary, English criminal procedure gives victims a somewhat limited role.

For comparative lawyers, France is the archetype of an inquisitorial procedure and the system used in England and Wales was once a pure representation of an adversarial criminal procedure.<sup>9</sup> However, both systems have acquired features of one another. For instance in France, there have been reforms to reinforce the rights of the suspect during custody, which is usually a feature of the adversarial type of procedure.<sup>10</sup> Since the creation of the Crown Prosecution Service (CPS) in 1986, English criminal procedure may have moved a little closer to the French system, although it remains mostly adversarial. The creation of the CPS in England was a demonstration of a move towards a more centralised justice system, which used to characterise the inquisitorial system.<sup>11</sup> Nonetheless, French and English criminal processes still include features which have a great impact on the different ways healthcare malpractice is criminalised.

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<sup>5</sup> J Hodgson, 'Hierarchy, Bureaucracy, and Ideology in French Criminal Justice: Some Empirical Observations' (2002) 29(2) *Journal of Law and Society* 227, 230.

<sup>6</sup> N Jorg, S Field, C Brants, above n3 at 52.

<sup>7</sup> Sénat, Les délits non intentionnels-La Loi Fauchon : 5 ans après-Actes du colloque, 1<sup>er</sup> mars 2006, Palais du Luxembourg, 58.

<sup>8</sup> *Constitutions de partie civile* are civil claims for compensation brought in criminal courts in French criminal proceedings. Victims who join *constitutions de partie civile* are called *parties civiles* because they are parties to the civil action in the criminal proceedings. Art 2-3 CPP; B Boulloc, H Matsopoulou, *Droit pénal général et procédure pénal* (18<sup>e</sup> edn, Sirey 2011) 179, 197.

<sup>9</sup> J Hodgson, above n5; F Pakes, *Comparative Criminal Justice* (Willan 2004) 86-90.

<sup>10</sup> Loi n° 2000-516 du 15 juin 2000 renforçant la protection de la présomption d'innocence et les droits des victimes.

<sup>11</sup> N Jorg, S Field, C Brants, above n3 at 46; J Hodgson, above n5 at 227.

### 3.3 The Role of Victims as *Parties Civiles*

The first feature of French criminal procedure which goes a long way in explaining why the criminal process has a wider use in France in healthcare malpractice is the fact that in France, victims can initiate criminal prosecutions by joining *constitutions de partie civile*. In the English criminal process, victims have a more limited role and do not have the right to join civil claims for compensation to any criminal proceedings.<sup>12</sup> At most, they can be involved in the investigations but they do not influence the process until sentencing.<sup>13</sup>

When a person is a victim of healthcare malpractice in France, she can choose to either sue for compensation in civil or administrative courts (depending on whether the defendant worked in private or public practice), or lodge a criminal complaint with or without *constitution de partie civile*. If the victim chooses to join a *constitution de partie civile* to a criminal complaint, the *Action Publique* will be launched.<sup>14</sup> To bring a civil claim for compensation before a criminal court, the victim has to demonstrate that the offence is punishable by criminal law and that it attacked a public interest and the victim has to show that she suffered a personal harm in direct relation to the offence, which may sometimes create a disincentive for victims to use the criminal process.<sup>15</sup> It is argued that notably in cases of healthcare malpractice, *constitutions de partie civile* usually occur after the *Ministère Public* (MP)<sup>16</sup> have informed the victims that they will not pursue the case as they do not consider it serious enough to merit punishment.<sup>17</sup> Then, the MP decide whether the case should be brought before a court or be resolved in an alternative way such as diversion (offender-victim mediation).<sup>18</sup> In serious and complex cases (which generally include cases of healthcare malpractice), the MP will decide to order an

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<sup>12</sup> A Sanders, 'Victims' voices, victims' interests and criminal justice in the healthcare setting' in D Griffiths, A Sanders (eds), *Medicine, Crime and Society* (Cambridge University Press Forthcoming 2013), 83.

<sup>13</sup> Ibid.

<sup>14</sup> B Boulloc, *Procédure Pénale* (23<sup>e</sup> edn, Dalloz 2012) 579.

<sup>15</sup> C Elliott, *French Criminal Law* (Willan 2001) 33.

<sup>16</sup> The public prosecution service may be called *Ministère Public* or *Parquet* in French.

<sup>17</sup> J Guigue, 'Les inconvénients de la pénalisation du droit de la santé' (2008) *Revue de droit sanitaire et social* 36 ; B Boulloc, above n14 at 579.

<sup>18</sup> F Pakes, above n9 at 80; As mentioned in Chapter 1, there is since 2002 an alternative way to claim for compensation for healthcare accidents in France. The no-fault compensation scheme ONIAM will be discussed in ch7 pt7.5.4, 232.

investigation by the JI.<sup>19</sup> An investigation conducted by a JI is crucial in healthcare malpractice cases in France.

In England, a victim cannot join a civil claim for damages to a prosecution even in the case of a private prosecution, which is a rare and expensive process.<sup>20</sup> In England, Griffiths and Sanders have found that victims and their family may only get a criminal investigation if the police listen or the coroner ‘pushes’ the case but the police do not have to investigate no matter how much victims want to prosecute.<sup>21</sup> Sanders states that in England, ‘there is no requirement that the prosecution take any particular heed of the wishes or interests of victims, receive information from victims, or provide information to victims’.<sup>22</sup> However, it is acknowledged that in England, ‘the families of victims seem to be increasingly engaged in inquests and in the work of coroners. Coroners and the police feel increasingly obliged to respond positively to the concerns of families’.<sup>23</sup> Nevertheless, victims do not usually influence investigations conducted by the police in the same manner as do *parties civiles* in France in the healthcare malpractice context.

A victim of healthcare malpractice in France may also bring a claim for compensation before a civil court, but in that case she will not be able to bring a civil action before a criminal court according to the maxim *electa una via, non datur recursus ad alteram* which means that once someone has chosen one way he cannot choose the other.<sup>24</sup> This is perhaps one of the reasons why victims of healthcare malpractice choose to be *parties civiles*. If they bring a legal action before a civil court and their action is not successful, they would have lost the opportunity to use the criminal process.

In France, the criminal process offers many advantages to victims of healthcare malpractice compared to other procedures. First of all, joining a civil claim for compensation to a criminal complaint may prove to be the easiest way for a victim to

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<sup>19</sup> P Verrest, ‘The French public prosecution service’ (2000) 8(3) *European Journal of Crime, Criminal Law and Criminal Justice* 210, 213.

<sup>20</sup> A Sanders, above n12 at 83; C Van Den Wyngaert, *Criminal Procedure Systems in the European Community* (LexisNexis UK 1993) 96-97.

<sup>21</sup> A Sanders, above n12 at 83.

<sup>22</sup> Ibid.

<sup>23</sup> Ibid 89.

<sup>24</sup> R Van Ruymbeke, above n2 at 18; F Vignaud, ‘La judiciarisation de la médecine, comparaison entre droit français et droit américain’, in D Dreyfuss, F Lemaire, H Outin (eds), *La judiciarisation de la médecine* (Médecine-Sciences Flammarion 2004) 7.

obtain financial compensation. Compensation at the end of criminal proceedings is awarded on the same basis as in civil proceedings and the standard of proof for the civil claim is the same as in civil courts.<sup>25</sup> Thus, the amount of civil damages awarded in criminal proceedings is equivalent to what would be awarded in civil proceedings for the same injury.<sup>26</sup> *Dommages-intérêts*<sup>27</sup> take into account bodily, material and moral damages caused by the defendant to the victim and his close relatives.<sup>28</sup> Given the principle of *identité des fautes civiles et pénales*, it was difficult to award civil compensation to victims when the defendant was acquitted. Judges used to admit a '*poussière de fautes*' (literally 'dust of negligence') to preserve the victims' right to civil compensation.<sup>29</sup> But since 2000, civil compensation may still be awarded to victims by civil courts even if the defendant was acquitted by criminal courts.<sup>30</sup> The *Loi Fauchon* altered the principle of *identité des fautes civiles et pénales* to ensure that victims are compensated for the harm caused.<sup>31</sup>

However, access to compensation may not be the principal factor motivating *parties civiles*. Bertella-Geffroy<sup>32</sup> stated that, in her experience, victims who choose to use the criminal process do not usually want to get financial compensation.<sup>33</sup> Notably she has pointed out that victims choose the criminal process because in France, criminal proceedings are mostly free for victims, whereas other proceedings entail expert costs.<sup>34</sup> In French criminal proceedings, expert-related expenses and criminal evidence-related expenses are provided by the justice system.<sup>35</sup> Hiring a lawyer is

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<sup>25</sup> JR Spencer, MA Brajeux, 'Criminal liability for negligence-A lesson from across the Channel?' (2010) 59(1) *International and Comparative Law Quarterly* 1, 10 ; D Thouvenin, *La responsabilité médicale, Analyse des données statistiques disponibles et des arrêts rendus par la cour de cassation et le conseil d'état de 1984 à 1992* (Médecine-Sciences Flammarion 1999) 12.

<sup>26</sup> JR Spencer, MA Brajeux, above n25.

<sup>27</sup> Civil damages.

<sup>28</sup> D Thouvenin, above n25 at 12, 48.

<sup>29</sup> Art 470-1 CPP; Crim. 14 January 1981, Bull n°24; Assemblée Nationale, Rapport n° 2266 fait au nom de la commission des lois constitutionnelles, de la législation et de l'administration générale de la République sur la proposition de loi, adoptée par le Sénat, tendant à préciser la définition des délits non intentionnels, par M René Dosièrre, 22 mars 2000, 17.

<sup>30</sup> Art 4-1 CPP.

<sup>31</sup> M Tapia, 'Décadence et fin éventuelle du principe d'identité des fautes pénales et civiles' (2003) 67 *Gazette du Palais*, 2.

<sup>32</sup> Marie-Odile Bertella-Geffroy was interviewed as part of the present study; Interview with Marie-Odile Bertella-Geffroy (Paris, France, 18 January 2011); See ch1, 32.

<sup>33</sup> Interview with Marie-Odile Bertella-Geffroy, above n32 at 11.

<sup>34</sup> Ibid; Sénat, above n7 at 58.

<sup>35</sup> M Daury-Fauveau, *La responsabilité pénale du médecin* (Les études hospitalières 2003) 45 ; Sénat, above n7 at 58.

optional but strongly recommended to facilitate proceedings for victims.<sup>36</sup> However, in a civil or administrative court, the victim would have to provide evidence and hire experts to support her claim. Victims choose to go down the criminal route also because criminal proceedings are said to be quicker than civil or administrative proceedings.<sup>37</sup> Bertella-Geffroy indicated that in her experience, victims who chose to use criminal proceedings over other proceedings were victims with no financial means and who were provided legal aid, or victims with relatives who were either doctors or lawyers and who knew that something had gone wrong.<sup>38</sup> This suggests that the French criminal process can give access to a greater number of victims.

In the English system, until 2012, legal aid was available to victims of healthcare malpractice but proposals were made to remove legal aid from healthcare malpractice cases.<sup>39</sup> The House of Lords tried to restore some legal aid but it is no longer possible to get legal aid for clinical negligence claims except where the negligence would have caused ‘a neurological injury to an individual’ which would have resulted in the individual being disabled, but only in his mother’s womb, during his birth or during his first 8 weeks of life.<sup>40</sup> Thus, from the first of April 2013, legal aid for victims of clinical negligence will only be available in these particular cases of clinical negligence in England. Children and adults who have been injured outside of these strict categories may wish to invoke the criminal process.

Griffiths’ and Sanders’ research found that in England, victims often want to use the criminal process because there is a lack of other means of accountability. Victims usually want explanations, rather than retribution, and the investigation itself often offers them the level of closure they need. Bertella-Geffroy claims that the main motivation of victims of healthcare malpractice to use the criminal process in France is that it gives them transparency on what happened thanks to investigations conducted by the JI who ‘searches for the truth’, and victims argue that they use the criminal process so that similar negligence does not occur in the future.<sup>41</sup> Means of investigation are greater in criminal proceedings than in civil or administrative proceedings in France so victims have more chances to understand the ‘truth’ in

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<sup>36</sup> Interview with Marie-Odile Bertella-Geffroy, above n32 at 8.

<sup>37</sup> Assemblée Nationale, above n29 at 5.

<sup>38</sup> Interview with Marie-Odile Bertella-Geffroy, above n32 at 11.

<sup>39</sup> Legal Aid, Sentencing and Punishment of Offenders Bill.

<sup>40</sup> Legal Aid, Sentencing and Punishment of Offenders Act 2012. Sch 1 para 23.

<sup>41</sup> Interview with Marie-Odile Bertella-Geffroy, above n32 at 11.

criminal proceedings than in other proceedings.<sup>42</sup> In French criminal procedure, victims' and defendants' advocates can obtain the investigative/prosecution file after their first hearing.<sup>43</sup> On the contrary, in England, victims have no access to the police and prosecution file.<sup>44</sup> French criminal procedure seems to respond more effectively to victims' demands for explanation and closure. In Chapter 7, I will argue that elements of the French system could be borrowed from the criminal process to be used in alternative proceedings to ensure transparency and closure.

Commentators agree that victims choose to use the criminal process for the reasons stated above.<sup>45</sup> But Memeteau argued that the only reason why victims in France choose to use the criminal process over other procedures is for pure vengeance.<sup>46</sup> He claimed that the great powers of investigation of the JI and the 'easiness' of the procedure in terms of evidence and burden of proof are not factors that influence the preference of the victims for the criminal law because civil procedure provides similar advantages in terms of *recherche de la vérité*.<sup>47</sup> However, Bertella-Geffroy disagreed arguing that victims choose the criminal process mostly because it gives them the 'truth', which they cannot have in civil or administrative procedures, or in adversarial proceedings.<sup>48</sup> The judge affirmed that JIs investigate in-depth and this gives victims the transparency they need, whereas in civil or administrative proceedings, they would rely on each party's documents, which do not necessarily analyse the case in-depth.<sup>49</sup> Bertella-Geffroy acknowledged that victims, although they do not necessarily admit it, do use the criminal process for vengeance and retribution sometimes in healthcare malpractice cases.<sup>50</sup>

Nonetheless, it is argued that what victims also want from using the criminal process is to see a conviction or even a scapegoat.<sup>51</sup> For example, in a case where a doctor had injected adrenaline into a patient contrary to her colleagues' advice, the victims

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<sup>42</sup> Assemblée Nationale, above n29 at 36.

<sup>43</sup> Art 114 al 4 CPP.

<sup>44</sup> A Sanders, above n12 at 145-146.

<sup>45</sup> Interview with Marie-Odile Bertella-Geffroy, above n32 at 11 ; A Laude, B Mathieu, D Tabuteau, *Droit de la santé* (3<sup>e</sup> edn, Presses Universitaires de France 2012) 480 ; M Dauray-Fauveau, above n35 at 45 ; N Carrère, 'Le juge pénal et les professionnels de santé' (2008) 283 *Gazette du Palais* 23.

<sup>46</sup> G Memeteau, *Traité de la responsabilité médicale* (Les études hospitalières 1996) 168.

<sup>47</sup> Ibid 168.

<sup>48</sup> Interview with Marie-Odile Bertella-Geffroy, above n32 at 9.

<sup>49</sup> Ibid.

<sup>50</sup> Ibid 10.

<sup>51</sup> Sénat, above n7 at 57 ; Assemblée Nationale, above n29 at 5.

argued that they just wanted the doctor to be found guilty.<sup>52</sup> In France, victims do not get retribution or a conviction when they go down the civil or administrative route. Moreover, victims want proceedings to be ‘public’ and ‘mediatised’.<sup>53</sup> French civil and administrative proceedings only offer a mostly ‘written’ procedure and short pleadings with no witnesses.<sup>54</sup> Criminal proceedings are more likely to be subject to media coverage.<sup>55</sup>

It is argued that in England too, there is increasing ‘public pressure, particularly from victims, to invoke the criminal process’.<sup>56</sup> This may result in ‘more police investigations and protracted inquests’.<sup>57</sup> However, the number of prosecutions still seems ‘lower than expected’.<sup>58</sup> Thus, we could perhaps argue that, had victims in England have the right to join civil claims for compensation in criminal courts as do French victims, the use of the criminal process would be greater, even though there are other factors at play in healthcare malpractice cases which have been explained in the previous chapter (notably, difficulty to establish causation and the uncertainty of the gross negligence test in England).<sup>59</sup>

### 3.4 The Role of Investigative Bodies

#### 3.4.1 The Role of the *Juge d’instruction* (JI)

The JI greatly impacts on the course of criminal proceedings involving negligent doctors in France. I argue that the role of the JI in French criminal procedure also explains the greater number of prosecutions and convictions of health professionals and institutions for negligence, particularly because of his wide powers of investigation and his close interaction with victims.

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<sup>52</sup> A Keller, ‘We just wanted the law to recognise our mum had been killed’, *Lichfield Mercury*, 12 February 2009.

<sup>53</sup> Sénat, above n7 at 57.

<sup>54</sup> Ibid.

<sup>55</sup> Assemblée Nationale, above n29 at 21.

<sup>56</sup> D Griffiths, A Sanders, ‘The road to the dock: prosecution decision-making in medical manslaughter cases’, in D Griffiths, A Sanders (eds), *Medicine, Crime and Society* (Cambridge University Press Forthcoming 2013) 146.

<sup>57</sup> Ibid.

<sup>58</sup> Ibid.

<sup>59</sup> Ibid 140-144.

In France, although preliminary investigations may be undertaken by the police in most cases, it appears that in the context of healthcare malpractice, the police have a limited role and investigations are usually conducted by one JI on his own (although several JIs might be in charge of the same investigation successively).<sup>60</sup> The *instruction*<sup>61</sup> aims to discover the ‘truth’<sup>62</sup> and to determine whether the case should be taken to court. Investigations conducted by the JI start either following a demand from the MP or a *constitution de parties civiles*.<sup>63</sup> The JI may choose to investigate in cases of *délits* (which include all criminal offences used in the context of healthcare malpractice).<sup>64</sup> The *parties civiles* and the MP can appeal his decision not to investigate.<sup>65</sup> In most cases of healthcare malpractice, the JI will investigate after being seized by the *Ministère Public*, especially if the case requires expert evidence.<sup>66</sup>

This part of French criminal procedure has been subject to debate since the last decade and reforms have been suggested in order to restrict the powers of the JI.<sup>67</sup> Until 2007, all *constitutions de partie civile* were received by the JI. Since 2007, the JI has to send the *constitutions de partie civile* to the MP so that they can make *réquisitions* to either order an investigation or close the case.<sup>68</sup> It was claimed that this has reduced the number of prosecutions of doctors for malpractice because the MP, much like the CPS, are generally more reluctant to prosecute cases of healthcare malpractice than JIs.<sup>69</sup> This was part of a reform that aimed to limit the role and powers of the JI and give the MP a stronger role.<sup>70</sup>

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<sup>60</sup> Investigations are conducted by one *juge d’instruction* but he may ask for help to the police or experts; V Dervieux, ‘The French system’ in M Delmas-Marty, JR Spencer (eds), *European Criminal Procedures* (Cambridge University Press 2002) 234; Interview with Marie-Odile Bertella-Geffroy, above n32; I Jamin, ‘La responsabilité pénale en milieu de soin: une préoccupation réelle, une menace relative?’ (2009) *Actualité Juridique Pénal*, 340.

<sup>61</sup> Criminal investigation conducted by the *juge d’instruction*.

<sup>62</sup> ‘*Recherche de la vérité*’; See above n1.

<sup>63</sup> Art 51 CPP.

<sup>64</sup> Art 79 CPP.

<sup>65</sup> B Boulloc, above n14 at 613.

<sup>66</sup> Interview with Marie-Odile Bertella-Geffroy, above n32.

<sup>67</sup> G Gaetner, ‘Les juges d’instruction sont les mal aimés du système pénal français’, *L’Express*, 8 janvier 2009.

<sup>68</sup> Art 86 al 1 CPP.

<sup>69</sup> Art 85 CPP; 86 CPP; Interview with Marie-Odile Bertella-Geffroy, above n32 at 2.

<sup>70</sup> Commission Justice pénale et Droits de l’homme, *La mise en état des affaires pénales*, Rapport final (La Documentation française, Paris 1991) 126–136.



The JI is considered to have wide coercive powers.<sup>71</sup> According to the *Code de Procédure Pénale* (CPP), he can carry out any ‘acts of procedure’ allowed by the law, which may be useful for establishing the truth.<sup>72</sup> He can for instance visit the scene of the crime, search, seize objects or documents, hear evidence from witnesses, and interrogate the victim(s) and the suspect(s).<sup>73</sup> He can also order the arrest of the suspect(s)<sup>74</sup> and use the police or experts to conduct the investigations and gather evidence through *commission rogatoire*<sup>75 76</sup>.

After analysing the evidence gathered during the investigations, the JI may *mettre en examen*<sup>77</sup> the defendant and request charges to be used against the defendant if he considers that there is sufficient evidence of commission of an offence. Once the JI has decided whether the case should be sent to court or charges should be dropped, the case goes to the MP. The MP may then make a decision on the prosecution. The conclusion of the JI on the case may thus greatly affect the decision of the MP as charges suggested by the JI may be followed by the MP who may rely on the information collected by the JI during the investigations to make a decision.<sup>78</sup>

Bertella-Geffroy argues that the impact of the JI on criminal proceedings involving ‘negligent’ healthcare professionals is largely due to his power to search and seize documents.<sup>79</sup> This is particularly true in complex cases where the error or negligence was a result of a chain of events and decisions. The JI may analyse in detail all the factors which led to the ‘accident’ and cast light on who was responsible, and she may choose to *mettre en examen* other healthcare professionals who were involved in the chain of causation.<sup>80</sup>

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<sup>71</sup> R Van Ruymbeke, above n2 at 48 ; J Hodgson, ‘The Police, the Prosecutor and the Juge d’Instruction’ (2001) 41(2) *The British Journal of Criminology*, 344.

<sup>72</sup> Art 81 CPP.

<sup>73</sup> Art 92 CPP; art 97 CPP; art 101 CPP; art 114 al 1 CPP.

<sup>74</sup> Art 122 CPP; However, there is no evidence that this may happen in healthcare malpractice cases.

<sup>75</sup> When the *juge d’instruction* cannot conduct certain acts of investigation himself, he may give *commission rogatoire* to police officers who will conduct these acts; art 81 al 4 CPP.

<sup>76</sup> Art 14 para 2 CPP; art 151 CPP.

<sup>77</sup> ‘*Mise en examen*’ is an act of the JI by which he requests that the case be pursued as there is enough evidence against the defendant. Art 80-1 al. 1 CPP.

<sup>78</sup> Interview with Marie-Odile Bertella-Geffroy, above n32.

<sup>79</sup> Ibid 10.

<sup>80</sup> Ibid.

Since the creation of *pôles de santé publique*<sup>81</sup> in France in 2003, victims of ‘systemic’ healthcare malpractice may refer to the *pôle de santé publique* in either Paris or Marseille after they have been sent to the MP. *Pôles de santé publique* were created specifically to treat cases of healthcare accidents and environmental disasters which involve systemic error or corporate failure and a great number of victims, such as the exposition to Asbestos or the contamination of the Human Growth Hormone with vCJD which both caused a great number of victims.<sup>82</sup> *Pôles de santé publique* were created to facilitate proceedings in that area. There are currently over 8 cases of systemic healthcare failure being investigated by the *pôle de santé publique* in Paris.<sup>83</sup> The fact that in France there exist a body specialised in cases of systemic healthcare failure also explains why the criminal process has a greater scope in France in healthcare malpractice. In *pôles de santé publique*, all *constitutions de parties de civiles* regarding the same case and alleged malpractice are gathered into one case file and the evidence is analysed together. However, as well as the case file which applies to the case altogether, each victim has his or her own case file assessing the level of harm and causal link between the negligence and the harm.<sup>84</sup> This can result in very complex procedures.<sup>85</sup> This highlights the necessity of a body with wide powers of investigation in the healthcare malpractice context. *Pôles de santé publique* include prosecutors, JIs, and specialised experts (doctors, a pharmacist and a veterinarian).<sup>86</sup> In Chapter 8<sup>87</sup>, I will discuss whether lessons can be learnt from the role of *pôles de santé publique* in France that we could utilise in England outside the criminal process.

On this side of the channel, criminal investigations are not conducted by a single judge with wide coercive powers. In England, when a healthcare related death occurs, investigations may be conducted by coroners and the police.<sup>88</sup> The role of the

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<sup>81</sup> *Pôles de santé publique* are authorities within criminal courts which are in charge of investigating cases of dangerous health products, foods or substance which have caused multiple victims; art 706-2 CPP ; M Obadia, ‘L’expérience d’un pôle de santé publique’ (2008) *Revue de droit sanitaire et social*, 44; MO Bertella-Geffroy, ‘Justice Pénale, Santé Individuelle et Santé Publique’ (2008) 128(2) *Droit de la Santé*, 14.

<sup>82</sup> Unknown author, ‘Scandale de l’amiante : 705 nouveaux dossiers de victimes’, *Le Point*, 4 Avril 2012 ; Interview with Marie-Odile Bertella-Geffroy, above n32 at 1.

<sup>83</sup> Interview with Marie-Odile Bertella-Geffroy, above n32 at 1.

<sup>84</sup> MO Bertella-Geffroy, above n81 at 14.

<sup>85</sup> M Obadia, above n81 at 44.

<sup>86</sup> Ibid; MO Bertella-Geffroy, above n81 at 14.

<sup>87</sup> See ch8 pt8.6, 255.

<sup>88</sup> D Griffiths, A Sanders, above n56 at 118.

coroner is to be distinguished from that of the police as the former is also involved in non-criminal cases. The role of the coroner is similar to the role of the *médecin légiste* in France, which is principally to determine the cause of the death. However, as we shall see in Chapter 7, coroners bear responsibilities that *médecin légiste* do not bear in terms of investigations and recommendations and which might be beneficial to use outside the criminal process to inform investigations on healthcare malpractice cases.<sup>89</sup> The role of the police in England is comparable to the role of the police in France. They may arrest or question the defendant, or conduct searches, but they may not decide on the prosecution of offenders or request charges like the JI in France but may share some of the functions undertaken by JIs.<sup>90</sup> Thus, the police in England have a more limited role than the JI in France and this seems to have an impact on the way cases of healthcare malpractice are investigated. Sanders states that ‘the police are not obliged to investigate everything, nor anything in particular, nor refer to other authorities if they decide to take no action about something they believe to be criminal’.<sup>91</sup> Moreover, the police seem to have less means and resources or do not gather as much evidence as the JI, and may not investigate certain cases that would be pursued in France. For example, the police closed a case where there was evidence that the death of the patient was a result of the doctor’s negligence, because ‘it was likely to take up more resources that we could bring to bear on it’.<sup>92</sup> As indicated earlier, in France JIs usually choose to investigate healthcare malpractice cases.

The Special Crime and Counter Terrorism Division (SCCTD) of the CPS is now in charge of all ‘medical manslaughter’ cases and should be consulted by the police at any early stage.<sup>93</sup> However, in practice, research has shown that they do not always do so.<sup>94</sup> The SCCTD bears some resemblance to the *pôles de santé publique* in France as they are both specialised bodies in charge of specific criminal cases. However, *pôles de santé publique* only specialise in cases of healthcare malpractice that result from systemic failure. The investigative role of *pôles de santé publique* on

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<sup>89</sup> Art 230-26 CPP; See ch7 pt7.5.3, 232.

<sup>90</sup> Police and Criminal Evidence Act 1984 s 1, s 8, s 24, s 54.

<sup>91</sup> A Sanders, above n12 at 86-87.

<sup>92</sup> D Griffiths, A Sanders, above n56 at 137.

<sup>93</sup> Ibid 119.

<sup>94</sup> Ibid.

cases of systemic failure could inform other mechanisms which could be used to prevent healthcare error and ensure safety, as will be shown in Chapter 8.<sup>95</sup>

In England, in addition to the conventional prosecution process, a second avenue exists in theory to hold health professionals and providers to account. In the case of death or serious injury at a workplace resulting from systemic failure, the police or the Health and Safety Executive (HSE) may conduct investigations under the Health and Safety at Work Act 1974 (HSWA 1974), which is to be seen as a scheme of regulation, similar to the regulatory nature of *délits* in France although *délits* are not specifically designed to preserve health and safety.<sup>96</sup> The police and the HSE decide on whether the case is worth investigating and so they may impact on the criminalisation of doctors at the earliest stage of the procedure just as the MP and the police would in French criminal procedure.<sup>97</sup> However, Griffiths and Sanders have found that the HSE do not usually get involved in healthcare cases because of a lack of resources, although in theory they could. So cases which should be investigated are not. The criminalisation of healthcare malpractice under the HSWA 1974 being similar to criminal proceedings using negligence *délits*, other factors seem to be responsible for the greater scope of criminal law in healthcare malpractice in France, in particular as we have seen, the extensive role of JIs and *parties civiles*.

### 3.4.2 The Role of Experts

The role of experts in criminal proceedings involving healthcare professionals in both countries is crucial.<sup>98</sup> Experts are in charge of assessing the level of compliance with proper practice of the accused according to good medical standards and attesting whether the accused was negligent as well as establishing a causal link

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<sup>95</sup> See ch8 pt8.6, 255.

<sup>96</sup> CMV Clarkson, HM Keating, SR Cunningham, *Criminal Law* (7<sup>th</sup> edn, Thompson Sweet and Maxwell 2010) 251-252.

<sup>97</sup> A Sanders, above n12 at 83.

<sup>98</sup> O Quick, 'Medical Manslaughter and Expert Evidence: the Role of context and character', in D Griffiths, A Sanders (eds), *Medicine, Crime and Society* (Cambridge University Press Forthcoming 2013) 102.

between the conduct and the harm.<sup>99</sup> Thus experts may have a great influence on criminal proceedings involving negligent healthcare practitioners.

Experts may have a role at a very early stage of the procedure. In both France and England, experts may be appointed to investigate on the case in preliminary investigations.<sup>100</sup> Unlike in the adversarial type of procedure, experts in the French criminal system are independent from the parties and not instructed by them, although the parties in the proceedings have the right to ask the JI for an expert to be appointed.<sup>101</sup> In French criminal procedure, experts are court-appointed and work closely with the JI.<sup>102</sup> During the pre-trial investigations conducted by the JI, only the JI can interpret evidence and he is the only authority that can decide to call upon one or several medical experts whenever he considers that the investigations require a professional opinion.<sup>103</sup> In France, criminal proceedings against healthcare practitioners or officials always involve medical experts.<sup>104</sup> Medical experts help the JI to evaluate the level of bodily harm and determine the cause of the harm.<sup>105</sup> Medical experts establish the causes of the malfunction, whether it was individual or collective and help to identify the person(s) responsible, if any.<sup>106</sup> The parties (including the MP, the defendants and the *parties civiles*) can ask the JI to appoint an expert to examine the case but they have to specify the questions they want to ask the expert.<sup>107</sup> The expert may interrogate the parties with the authorisation of the JI and of the concerned party.<sup>108</sup> During the course of expert's investigations, the parties may ask the JI for the expert to investigate in a certain way or interrogate certain persons that they have identified who are likely to bring useful information to the case.<sup>109</sup> At all times, experts work with the JI, and not with the parties to the legal

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<sup>99</sup> O Quick, 'Expert Evidence and Medical Manslaughter: Vagueness in Action' (2011) 38(4) *Journal of Law and Society* 496, 497; A Merry, A McCall Smith, *Errors, Medicine and the Law* (Cambridge University Press 2001) 176-203; J Hureau, D Poitout, *L'expertise médicale en responsabilité médicale et en réparation d'un préjudice corporel* (3<sup>e</sup> edn, Masson 2010) 9.

<sup>100</sup> Art 60 CPP; D Griffiths, A Sanders, above n56 at 119.

<sup>101</sup> Art 156 CPP.

<sup>102</sup> Art 156 CPP.

<sup>103</sup> Art 156 CPP; art 159 CPP; P Feuillet, F Thorin, *Guide Pratique de l'expertise judiciaire* (Litec 1991) 25.

<sup>104</sup> MO Bertella-Geffroy, above n81.

<sup>105</sup> Ibid 8-9.

<sup>106</sup> Ibid.

<sup>107</sup> Art 156 CPP.

<sup>108</sup> Art 164 al 2 CPP.

<sup>109</sup> Art 165 CPP.

action.<sup>110</sup> Experts are required to inform the JI about the evolution of their research.<sup>111</sup> In French criminal procedure,

The report of the court expert (or experts) is circulated to the parties, and they then discuss it at a special hearing before the [JI], which takes place in private, and well ahead of the final trial. The experts can be questioned about their reports, and if the parties are not satisfied by their answers, they can ask the [JI] to appoint a further expert, or experts.<sup>112</sup>

Spencer has claimed that experts are of a higher quality in France than in England.<sup>113</sup>

In the pre-trial phase in the English criminal process, the police are usually given advice by the SCCTD on the ‘legal tests that need to be met and the appropriate experts from whom to seek expert reports’.<sup>114</sup> However, it has happened that sometimes the police would not follow the advice and went on to carry ‘full investigations before consulting the CPS’, and thus ‘inadvertently set some cases on lengthy paths that could not lead to successful prosecutions’.<sup>115</sup> In England, if the case goes to trial, the defendant has his own expert and thus, there is more potential for disagreement later on in the proceedings, which may affect the CPS’ decision about prosecution. Griffiths and Sanders have found in their research that it was often the case that inappropriate experts were chosen during the investigations. For example, a General Practitioner expert was chosen to comment on a case of emergency medicine.<sup>116</sup>

In cases of ‘medical manslaughter’ in England, experts have difficulty interpreting the *Adomako* test of gross negligence as, I have demonstrated in the previous chapter, it is vague and circular, and this may explain the smaller number of prosecutions against doctors in England because in France, the definition of criminal negligence leaves minimal room for interpretation.<sup>117</sup> Quick has noted that experts also ‘enjoyed considerable freedom when evaluating the conduct of the accused, and developed

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<sup>110</sup> Art 156 CPP.

<sup>111</sup> Art 161 al 3 CPP.

<sup>112</sup> JR Spencer, ‘The Neutral Expert: An Implausible Bogey’ (1991) 57(3) *Arbitration* 191, 192.

<sup>113</sup> *Ibid* 193.

<sup>114</sup> D Griffiths, A Sanders, above n56 at 119.

<sup>115</sup> *Ibid*.

<sup>116</sup> This was found in Griffiths’ and Sanders’ research on CPS files.

<sup>117</sup> O Quick, ‘Medical Killing: Need for a Specific Offence?’ in CMV Clarkson, S Cunningham (eds), *Criminal Liability for Non-Aggressive Death* (Ashgate 2008) 161; O Quick, ‘Medicine, mistakes and manslaughter: a criminal combination?’ (2010) 69(1) *Cambridge Law Journal* 186.

their own working rules and guidelines for assessing gross negligence'.<sup>118</sup> Thus, in England, the current offence of GNM provides for greater premium on experts on causation. The same example used in the previous chapter is interesting regarding experts and causation. As illustrated in Chapter 2, a baby had died five days following its birth because one midwife in charge of pre-labour and labour, had committed 'serious omissions [...] including lack of treatment of worsening symptoms in the mother over a two day period'.<sup>119</sup> Experts struggled to establish the causal link and were reluctant to conclude 'beyond reasonable doubt that but for the midwife's numerous acts and omissions, the baby would have survived'.<sup>120</sup> In France, experts found a direct causal link in a case where a doctor had agreed to operate on an elderly patient who was at high risk of thrombosis. The doctor was convicted of *homicide involontaire*.<sup>121</sup> They found an indirect causal link in a case where a young girl was admitted to hospital for a tonsillectomy. Post-surgery complications were signalled by nurses several times but the patient was treated negligently by the surgeon and the anaesthetist for a long period of time and without prescribing any particular checking to nurses. The doctors were convicted of *homicide involontaire* because experts found that they had indirectly caused the death of the patient.<sup>122</sup>

Experts affect the trial stage of the proceedings. At the trial in French criminal procedure, judges may call experts.<sup>123</sup> Questions might be asked to the experts by the president of the court, the MP or victims' advocates.<sup>124</sup> In French criminal procedure, each party has the right to call their own experts as witnesses but they rarely do so because it is cheaper and more convenient to ask the JI to appoint further experts.<sup>125</sup> Spencer argues that French criminal procedure is cheaper and more convenient than

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<sup>118</sup> O Quick, 'Medical Manslaughter and Expert Evidence: the Role of Context and Character', above n99 at 103.

<sup>119</sup> D Griffiths, A Sanders, above n56 at 141.

<sup>120</sup> Ibid.

<sup>121</sup> See ch2, 59.

<sup>122</sup> Crim. 13 février 2007, n° 06-82-202, au bulletin, JCP G 2007, II, 10107, note P. Mistretta; I, 187, M. Veron.

<sup>123</sup> Art 156 al 1 CPP.

<sup>124</sup> Art 442-1 CPP.

<sup>125</sup> JR Spencer, above n112 at 193.

English criminal procedure because court experts ‘do not have to waste hundreds of expensive hours sitting in court listening to oral evidence being laboriously given’.<sup>126</sup>

As mentioned earlier, in the English criminal process, once a decision is made about prosecution and the case goes to trial, experts are chosen by the parties and both the prosecution and the accused have their own expert, or experts. In theory, experts must have their independent expertise. However, it may seem that unlike experts in French criminal law procedure, experts in England are more prone to ‘deliver the view conducive to the party paying her, rather than a neutral, compassionate account’.<sup>127</sup> In England, experts may also guide the jurors in their decision to convict. Experts in English criminal procedure are sometimes victims of the adversarial process. As Roberts and Zuckerman argues, experts may be ‘lured or manoeuvred into adopting adversarial postures by lawyers looking for just a little bit more “clarification” or certainty on the expression of an opinion’.<sup>128</sup> As an example, Dr Nikkhah was prosecuted for having prescribed penicillin to a patient even though she was told that he was allergic to penicillin. The patient died of a heart attack. At the trial, the jury heard defence experts who said that the patient could have died of a heart attack even if he did not have an adverse reaction to the drug’.<sup>129</sup> The doctor was found not guilty. In this example, defence experts clearly made a statement in favour of the defendant when there was clear evidence that the doctor had prescribed her patient a substance which she knew he was allergic to. This example shows how influential experts in the adversarial procedure may be in healthcare malpractice. The fact that in France experts are usually appointed by the justice system ensures that cases are dealt with more objectively and contributes to the greater number of convictions of doctors in France as experts have limited freedom in their interpretation.

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<sup>126</sup> Ibid.

<sup>127</sup> M Coen, L Heffernan, ‘Juror comprehension of expert evidence: a reform agenda’ (2010) 3 *Criminal Law Review* 195, 209.

<sup>128</sup> P Roberts, A Zuckerman, *Criminal Evidence* (2<sup>nd</sup> edn, Oxford University Press 2010) 480.

<sup>129</sup> S Abel, ‘Doctor cleared of killing penicillin patient’, *Western Morning News* (Plymouth, 28 November 2008)



### 3.4.3 The Role of the Defendant

The conduct of the defendant during the proceedings may have a great impact on his prosecution and conviction. In France, the defendant might be heard by the JI as part of the investigations.<sup>130</sup> Bertella-Geffroy has argued that when health professionals or officials are heard by the JI they very often refuse to admit that they committed a wrong and refuse to apologise.<sup>131</sup> Thus, the attitude of the accused during the investigations may impact on the decision of the JI and the MP on whether to commit him to trial and also on the decision of the court on his culpability at the end of the proceedings.

In England, during the investigations, the defendant may be interviewed during pre-trial investigations. It seems that in England, the personality of the defendant is also a major factor influencing his prosecution and conviction. Quick has argued that ‘families, colleagues, investigators, prosecutors and experts are likely to be swayed by evidence of what they perceive as good or bad character traits of the individual as a criminal case is considered’.<sup>132</sup> Elements of ‘bad’ character often impacted on the prosecution and the conviction of healthcare professionals. Griffiths and Sanders found that ‘many prosecutors [said] that such elements of ‘badness’ were often crucial in securing a guilty verdict’.<sup>133</sup> For instance, ‘a prosecutor described how one doctor displayed great arrogance and little remorse’.<sup>134</sup> Dr Ramnath was found guilty of GNM for having injected adrenaline into a patient, contrary to her colleagues’ advice.<sup>135</sup> At the trial, the judge declared: ‘your arrogance has cost you your reputation’.<sup>136</sup> The doctor was given a 6 months suspended sentence.<sup>137</sup> Dr Kokkarne had prescribed the wrong dosage of oral morphine to two elderly patients with dementia who then died as a consequence. He was prosecuted for GNM. The doctor was known to be a ‘good’ man and a conscientious doctor. He was found not guilty.<sup>138</sup> On the other hand, a consultant urologist had failed to investigate a patient

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<sup>130</sup> Art 114 al 1 CPP.

<sup>131</sup> Interview with Marie-Odile Bertella-Geffroy, above n32.

<sup>132</sup> O Quick, ‘Medicines, mistakes and manslaughter: a criminal combination?’ above n117 at 194.

<sup>133</sup> D Griffiths, A Sanders, above n56 at 138.

<sup>134</sup> Ibid.

<sup>135</sup> O Bowcott, ‘Doctor guilty of patient manslaughter’, *The Guardian*, 6 February 2009.

<sup>136</sup> A Keller, ‘Doctor found guilty of manslaughter’, *Litchfield Mercury*, 12 February 2009.

<sup>137</sup> O Bowcott, above n135.

<sup>138</sup> I rely on an account of Dr Kokkarne’s and Dr Garg’s trials provided by a postgraduate student within the AHRC project.

who had abdominal pain and pain on passing urine. He had failed to treat her promptly and this caused her to die. The doctor was prosecuted for GNM. It was said that the doctor's behaviour constituted a serious departure of standard practice. This was aggravated by the fact that the doctor had tried to cover up his mistakes. He pleaded guilty, was convicted of GNM and sentenced to 2 years in prison.<sup>139</sup> This is one of the rare cases where an immediate prison sentence was imposed in the context of healthcare malpractice in England.<sup>140</sup> Thus, the reluctance to sentence doctors to jail may be greater in England because in theory the maximum sentence for a conviction for GNM is life imprisonment whereas it is 5 years maximum for negligence *délits* in France, even though actual jail sentences are rarely pronounced against doctors in both countries.

### 3.5 The Role of Prosecution Bodies

The final decision to prosecute health professionals, officials or institutions for 'negligence' offences rests on the MP in France and the CPS in England. The HSE have a role in investigating and prosecuting offences under the Health and Safety at Work Act 1974 (HSWA 1974) but at present do not prosecute individuals.

The role of the MP and the CPS in cases of healthcare malpractice in French and English criminal procedures are similar. In France, the MP, when making a decision on whether or not to prosecute, look at whether the offender breached the law and if a prosecution is in the interest of the society.<sup>141</sup> In England, the CPS also look at the appropriateness of the prosecution. The CPS decide whether to prosecute a case by raising two questions: the sufficiency of the evidence and the 'public interest' criterion.<sup>142</sup> The requirement of sufficiency of the evidence is fulfilled when it seems that it is more likely than not that the defendant will be convicted and the evidence is admissible and reliable.<sup>143</sup> Then the case has to pass the public interest stage. Usually a case will pass this stage when it is of such character that a prosecution is required

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<sup>139</sup> Ibid.

<sup>140</sup> Ibid.

<sup>141</sup> Art 40-1 CPP; B Bouloc, above n14 at 580-582; V Dervieux, above n60 at 232.

<sup>142</sup> Code for Crown Prosecutors 2010 4.1.

<sup>143</sup> N Padfield, *Text and Materials on the Criminal Justice Process* (4<sup>th</sup> edn, LexisNexis Butterworths 2008) 186; Code for Crown Prosecutors 2010 4.10.

in the public interest.<sup>144</sup> This raises the question of whether the MP and the CPS view cases of healthcare malpractice as going against the interest of the society. Usually in England, the CPS consider that a case should be prosecuted only when there is evidence of blameworthiness.<sup>145</sup>

Bertella-Geffroy stated that the MP are generally very reluctant to prosecute and JIs have a great role in ‘pushing’ cases of healthcare malpractice to court.<sup>146</sup> Similarly in England, it has been found that the CPS are cautious in their decision to prosecute doctors for negligence offences and there are no equivalents to the JIs to encourage prosecutors to prosecute.<sup>147</sup>

In France, the MP can prosecute for simple negligence when the causal link was direct whereas in England, the CPS may only prosecute gross negligence that resulted in death.<sup>148</sup> Moreover, the current GNM test is not clear and this seems to limit the number of prosecutions for healthcare malpractice.<sup>149</sup> Quick states that ‘the definition of [GNM] depends on the use of discretion by prosecutors’.<sup>150</sup> On the contrary in France, if the investigations conducted by the JI showed evidence that the conduct matched any of the negligence offences in the *Code Pénal*, and if the JI has suggested charges, prosecutors might have less freedom in the interpretation of the offence.<sup>151</sup> According to Griffiths’ and Sanders’ empirical research which reviewed 75 files referred to the SCTDD for ‘medical manslaughter’ in England, only four cases were prosecuted, resulting in two convictions. The CPS have shown some reluctance to prosecute doctors unless there was great evidence of subjective recklessness.<sup>152</sup> Moreover, Griffiths and Sanders have found that CPS prosecution files often contain the likely views of the jury on the case, because judges and juries do not like to see doctors in front of them in courts.<sup>153</sup> So the CPS only prosecute when it is likely that the jury will find the defendant guilty. In France, approximately

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<sup>144</sup> Code for Crown Prosecutors 2010 4.10.

<sup>145</sup> D Griffiths, A Sanders, above n56 at 126.

<sup>146</sup> Interview with Marie-Odile Bertella-Geffroy, above n32 at 2.

<sup>147</sup> D Griffiths, A Sanders, above n56 at 146.

<sup>148</sup> Brazier M, Alghrani A, ‘Fatal Medical Malpractice and Criminal Liability’ (2009) 25(2) *Journal of Professional Negligence*, 51.

<sup>149</sup> A Sanders, above n12 at 136.

<sup>150</sup> O Quick, ‘Prosecuting ‘Gross’ Medical Negligence: Manslaughter, Discretion and the Crown Prosecution Service’ (2006) 33(3) *Journal of Law and Society* 421, 429.

<sup>151</sup> See ch2 pt2.3, 42; D Griffiths, A Sanders, above n56; O Quick, ‘Medical Killing: Need for a Specific Offence?’, above n117 at 161.

<sup>152</sup> D Griffiths, A Sanders, above n56 at 143.

<sup>153</sup> *Ibid* 135.

33% of investigated cases of healthcare malpractice are prosecuted, whereas in England only 5% proceed to prosecution.<sup>154</sup> Griffiths' and Sanders' research has shown that the CPS considered that in 27% of cases (20 cases) there was no breach of duty, 13 cases involved negligence but failed to reach the 'gross' threshold and 33 cases lacked sufficient causal link or expert evidence was not strong enough.<sup>155</sup> The reluctance of the CPS to prosecute means that the difference in practice of the use of the criminal law in cases of healthcare malpractice in France and England is even greater. The CPS do not prosecute when no death ensued or when the causation or the threshold of gross negligence could not be proven in healthcare malpractice cases. Griffiths and Sanders thus argue for the creation of non-fatal offences to mitigate the element of luck in these cases.<sup>156</sup>

In order to provide a fuller picture of prosecutions in the context of healthcare malpractice, it is worth looking briefly at the role of the HSE in that context. In theory, the CPS and the HSE work together in cases of work-related deaths in particular when there is evidence that a serious criminal offence or a health and safety offence has been committed. According to their protocol for liaison in work-related deaths, they have to work 'together to investigate thoroughly, and to prosecute appropriately, those responsible for work-related deaths in England and Wales'.<sup>157</sup> Wells argues that the HSE only prosecute the worst cases and thus the conviction rate is high.<sup>158</sup> In 2010/11, the HSE prosecuted 551 cases (including non-medical cases) and the conviction rate was of 94% which is much higher than the usual rate of conviction in this type of cases.<sup>159</sup>

### 3.6 The Role of Juries and Judges

The jury is another important difference between the French and English systems of criminal procedure. Whereas in England, juries are an essential feature of the criminal process, they have a much lesser role in France. Only the *Cour d'Assises*

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<sup>154</sup> See Ch2, 37-38.

<sup>155</sup> D Griffiths, A Sanders, above n56 at 138-139, 142; See pt3.4.2, 76.

<sup>156</sup> D Griffiths, A Sanders, above n56 at 127.

<sup>157</sup> See <<http://www.cps.gov.uk/publications/agencies/wrdprotocol.html>>.

<sup>158</sup> C Wells, 'Medical manslaughter: organisational liability' in D Griffiths, A Sanders (eds), *Medicine, Crime and Society* (Cambridge University Press Forthcoming 2013) 197.

<sup>159</sup> See <<http://www.hse.gov.uk/statistics/overall/hssh1011.pdf>>.

which deals with *crimes* (most serious offences) in France involves a jury. The other criminal courts (*Tribunal de police* and *Tribunal correctionnel*), which deal with healthcare malpractice cases because they are cases of either *délits* or *contraventions*, do not involve a jury. Therefore, in France, juries have no role in cases of healthcare malpractice. On the contrary in England, juries may play a crucial part in proceedings involving doctors or health officials prosecuted for GNM or health institutions prosecuted for corporate manslaughter.

In England, the question of whether the alleged negligent conduct was gross and amounted to a criminal offence is left to jurors for both individual GNM and corporate manslaughter. This was held in *Prentice, Sullman and Adomako*. GNM is the:

Indifference to an obvious risk of injury to health, actual foresight of the risk coupled with the determination nevertheless to run it, an appreciation of the risk coupled with the intention to avoid it but also coupled with such a high degree of negligence in the attempted avoidance as the jury consider justifies conviction.<sup>160</sup>

In *Adomako*, it was held that:

Gross negligence[...]depends[...]on the seriousness of the breach of the duty committed by the defendant in all the circumstances in which he was placed when it occurred and whether, having regard to the risk of death involved, the conduct of the defendant was so bad in all the circumstances as to amount in the jury's judgment to a criminal act or omission.<sup>161</sup>

Similarly, the Corporate Manslaughter and Corporate Homicide Act 2007 provides that 'it falls to the jury to decide whether there was a gross breach' of a relevant duty of care.<sup>162</sup> In England, the jury decides whether the defendant is guilty but the question of sentence is entirely decided by the judge.<sup>163</sup> Juries make their decision based on issues of fact.<sup>164</sup> They give no reason for their decision and therefore it is difficult to challenge a verdict. Quick states that 'juries are free to independently

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<sup>160</sup> *R v Prentice, R v Sullman* [1994] QB 302; *Adomako* [1994] 3 WLR 288, 295.

<sup>161</sup> [1994] 3 WLR 288, 295.

<sup>162</sup> Corporate Manslaughter and Corporate Homicide Act 2007 s 8 (1).

<sup>163</sup> N Padfield, above n143 at 343.

<sup>164</sup> *Ibid* 376.

evaluate the competing expert evidence'.<sup>165</sup> Thus, whereas in France the decision on whether a health practitioner or official or a health institution is criminally liable for negligent conduct rests on judges, in England, the decision on whether their conduct amounted to gross negligence rests on the jury. It was argued that '...juries are frequently incapable of critically evaluating expert testimony, are easily confused, give inordinate weight to expert evidence, are awed by science [and] defer to the opinions of unreliable experts'.<sup>166</sup>

The involvement of jury and the current test of gross negligence can lead to inconsistencies in convictions of doctors for GNM. Quick states that 'juries are not asked to assess different scientific theories but instead, to consider contrasting opinions on how excusable or inexcusable certain conduct was. This task of ascribing responsibility for the conduct in question is mainly a moral, not a medical, matter'.<sup>167</sup> Like the CPS, jurors seem to be reluctant to convict doctors when there is no evidence of subjective recklessness.<sup>168</sup> On the other hand in France, it is claimed that judges have increasingly been more severe in the conviction of doctors in that they admit the conviction of doctors more easily than before.<sup>169</sup> Quick argues that the conviction rate of juries in 'medical' manslaughter cases in England is of 39%, which, he argues, is 'considerably lower than of manslaughter prosecutions generally'.<sup>170</sup> Thus, the involvement of a jury in English criminal proceedings for healthcare malpractice may also explain the more limited scope of criminalisation for negligence of health practitioners, officials or health institutions.

### 3.7 Conclusion

The chapter examined the role of criminal procedure in healthcare malpractice in France and England. The chapter revealed that French criminal procedure includes features which help to explain the wider use of criminal proceedings in healthcare

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<sup>165</sup> O Quick, 'Expert Evidence and Medical Manslaughter: Vagueness in Action', above n99 at 503.

<sup>166</sup> N Vidmar, R Lempert, S Seidman Diamond, V Hans, S Landman et al. 'Amicus brief: *Kumho Tire v Carmichael*' (2000) 24 *Law and Human Behaviour* 387, 388.

<sup>167</sup> O Quick, 'Expert Evidence and Medical Manslaughter: Vagueness in Action', above n99 at 501.

<sup>168</sup> D Griffiths, A Sanders, above n56 at 145.

<sup>169</sup> P Hennion-Jacquet, 'Quelques aspects de l'ambivalence des responsabilités pénale et civile du praticien' (2004) 14 *Revue générale de droit médicale*, 286.

<sup>170</sup> O Quick, 'Medical Killing: Need for a Specific Offence?', above n117 at 161.

malpractice than in England. Features of the French inquisitorial process go a long way in explaining the wider criminalisation of healthcare malpractice in France. Victims who act as *parties civiles* in France may be greatly involved in the proceedings and thus have a significant impact on the number of prosecutions against doctors for malpractice. Most cases of healthcare malpractice are prosecuted thanks to the involvement of *parties civiles*, as the MP would not prosecute such cases. The advantages of using the criminal process are an incentive for victims of healthcare malpractice in France. In particular, criminal investigations conducted by the JI who has wide coercive powers of investigation, provides victims with an explanation and transparency on what happened and make the burden of proof easier for victims. On this side of the channel, victims have a more limited role and do not have the right to launch prosecutions against healthcare professionals, although victims in England sometimes influence the decision of the police to investigate. JIs in France have wider powers of investigation and are often in favour of the victims to prosecute doctors for malpractice. Experts who work closely with the JI are more likely to be impartial and usually apply the test of negligence more appropriately than experts in English criminal procedure who may struggle to identify the *Adomako* test of gross negligence because of the circularity of its definition. In both France and England, prosecutors are reluctant to prosecute and convict doctors for involuntary conduct. However, in France, the MP might prosecute for simple negligence, whereas in England, the CPS may only prosecute for GNM and the CPS apply a high threshold in considering what is 'gross'. Moreover, the number of cases of healthcare malpractice prosecuted in France is higher than in England. The role of the jury in England is also a major factor which explains why healthcare malpractice is less criminalised in England, as the jury have difficulty in interpreting the test of gross negligence and are generally reluctant to convict doctors, whereas judges in France seem to be keener to convict. While I will argue later in the thesis that France should not be used as a model for the criminalisation of healthcare malpractice, I will suggest that some elements of the French inquisitorial system could be usefully copied outside the criminal justice system itself. That is the role of the JI to help promote robust investigations of the facts by an independent party and a greater role given to the involvement of victims.

## **4. Comparing Responses to the HIV-Blood Contamination in France and England in the 1980s**

### **4.1 Introduction**

In Chapters 2 and 3, I examined how and why the criminal process plays a larger role in France than England in holding individual doctors and health institutions to account for error and poor practice. In France, healthcare malpractice may be criminalised at the level of simple negligence and when it results in injury short of death, whereas in England, usually only gross negligence manslaughter (GNM) is criminalised. French criminal procedure offers a greater scope for the criminalisation of healthcare malpractice than English criminal procedure, with the role of victims as *parties civiles* and the *juge d'instruction* as well as the absence of a jury in healthcare malpractice cases. I began to demonstrate that aspects of French criminal law may be beneficial in terms of responding to victims' demands for understanding and closure which, I will argue in Chapters 7 and 8, should serve other types of proceedings.

In the following chapters, I examine a well known 'scandal' in the health services of both France and England: the contamination of blood supplies with HIV between 1983 and 1986. The episode is used as a point of reference to develop the analysis on the use of the criminal law in healthcare malpractice and cast further light on the issues addressed in Chapters 2 and 3. It will be shown that once again in France, much greater use was made of resort to the criminal process than in England in the context of healthcare malpractice. The contaminated blood episode is used here to find out why France tends to rely much more than England on the criminal process when healthcare accidents occur at the systemic level and discuss whether the French approach was the right one to deal with the episode.

In France, the episode led to three sets of criminal proceedings involving blood officials, treating doctors and ministers. In England, although one police investigation was begun in 2002/3 against senior ministers and civil servants, no prosecutions followed.<sup>1</sup> I was unable to find any more information on this but as the

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<sup>1</sup> D Black, 'Police drop 'bad blood' scandal', *The Journal* (Newcastle, 7 July 2003).



next chapter will show, in practice the only English offence likely to have resulted in prosecutions in this area is GNM. However, the Crown Prosecution Service (CPS) decided not to prosecute because experts claimed that it would be impossible to prove that health officials had authorised blood imports knowing that they were contaminated.<sup>2</sup>

In this and next chapter, I identify some of the factors responsible for the different responses to a similar healthcare malpractice episode in France and England. This will assist me in my aim of considering the scope and utility of the criminal process in healthcare malpractice and determine what role (if any) the criminal law should play in regulating healthcare malpractice. Why was criminal law used in France against doctors, health officials and ministers in the HIV-contaminated blood episode and barely even considered in England? I argue that significant differences in moral culpability do not explain why there were prosecutions in France and not in England, but rather, differences in the range of offences and features of criminal procedure seem to have been major factors which have influenced the prosecutions of healthcare providers in this context. Analysing differences in moral culpability will permit me to establish whether potentially there was criminal liability in the episode and what type of offences should be used regarding the conduct.<sup>3</sup> It will also be noted that while it has been argued that political and social factors had a significant impact on the use of the criminal law in the scandal, features of substantive criminal law and criminal procedure had a determinant impact on the use of the criminal law in the episode.

The present chapter aims to compare the failure of both French and English blood authorities and officials to respond adequately to the HIV-contamination of the blood supply. It will be shown that the failures to respond appropriately to the contamination demonstrated the same level of moral culpability in France and England apart from one exception. As explained in Chapter 2<sup>4</sup>, simple negligence is seen in both France and England as a failure to meet the required professional standards even in circumstances where the individual may have done his best taking

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<sup>2</sup> Ibid.

<sup>3</sup> See ch6 pt6.2, 160.

<sup>4</sup> See ch2 pt2.4, 51.

into account inexperience or pressures of the job.<sup>5</sup> Gross negligence is an indifference to a risk and does not involve a subjective element. Recklessness is the fact of 'knowing that an action or omission will involve an unacceptable level of risk to someone or something and deciding nevertheless to take that risk'.<sup>6</sup>

In later chapters, I argue that the threshold for criminal liability should involve a degree of moral culpability which should be at least at the level of recklessness. In this chapter, I suggest that both French and English health officials/authorities met the threshold of culpability in some areas of the decision-making process. They knew of the risk of contamination but nevertheless ran an unacceptable risk in the decision-making process relating to HIV contamination of the blood supply. In many facets of the decision-making process, however, culpability is hard to establish and these failures contributed to the complexity of the case and the failure of most French criminal prosecutions.

I will in the next chapters demonstrate that multiple factors in the background to the episode ie underestimation of the risk, disorganisation of national blood supplies, the uncertainty of scientific evidence on HIV/AIDS at the time, made the episode hard to fit with the criminal process and for the most part, except for cases where officials acted with disregard for the safety of blood patients for bad motives, the criminal law had little useful to do. Victims, families, and the media found it difficult however to distinguish between the different failures on the part of health officials and health authorities.

In both France and England, victims, the media and the public criticised the responses given by national blood authorities to the contamination. In both countries, these grievances were based on similar facets of the decision-making process related to the supply of blood products to people with Haemophilia<sup>7</sup> (PWH) and blood

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<sup>5</sup> See *Wilshire v Essex Area Health Authority* [1986] 3 All ER 801 (CA).

<sup>6</sup> A Merry and A McCall Smith, *Errors, Medicine and the Law* (Cambridge University Press 2001) 102.

<sup>7</sup> Haemophilia is a genetic disease transmitted by women to boys. There are two types of Haemophilia, A and B. Haemophilia A (85 % of PWH) is a lack Factor VIII in their blood, and Haemophilia B is a lack Factor IX. These factors are necessary for blood clotting. PWH thus suffer internal bleeding as soon as they slightly get injured. Since the 1970, PWH can be treated with injection of factor concentrates. This was one of the causes of the contamination since factor concentrates were made from blood sample donated by 1000 to 5000 donors. L Montagnier, *Des virus et des hommes* (Odile-Jacob 1994) 233-235; Rt Hon Lord Archer of Sandwell QC, Independent Public Inquiry Report on NHS Supplied Contaminated Blood and Blood Products, 23 February 2009, 10; See <[archercbbp.com](http://archercbbp.com)>.

recipients between 1983 and 1986. These failures were the failure to achieve self-sufficiency in factor concentrates (FCs), the failure to set up donor screening and HIV-testing early enough and the failure to heat-treat FCs soon enough. Doctors and health officials were also said to have knowingly supplied contaminated FCs to patients and failed to inform patients of the risk of contamination in FCs and blood products provided to blood recipients. In both countries, it was argued that the failure on the part of blood authorities to respond to the contamination was due to the failure to use financial resources appropriately. It was said that English authorities had been guilty of ‘gross maladministration’.<sup>8</sup> However, one significant difference was that in France, grievances were also based on the failure on the part of blood authorities to stop blood collections from prisons which did not happen in England. The failure of both French and English blood authorities to respond quickly and adequately to the contamination resulted in high levels of HIV-infection among PWH and blood recipients. As at 1992, 38.6% of Haemophilia patients and 5.2 % of blood transfusion recipients were contaminated with HIV in France.<sup>9</sup> At the same date, 34% of Haemophilia patients and 1.2% of blood transfusion recipients were contaminated with HIV in England.<sup>10</sup>

These grievances gave rise to the use of three sets of criminal proceedings in France. In 1992 in France, the director of the *Centre National de Transfusion Sanguine* (CNTS), Michel Garretta and the director of the department of research and development in the CNTS, Jean-Pierre Allain, were convicted of *tromperie*<sup>11</sup> and jailed.<sup>12</sup> The Director General of Health, Jacques Roux, and the Director of the National Health Laboratory, Robert Netter, were convicted of *non-assistance à personne en danger*.<sup>13</sup> In 1999, Laurent Fabius, Edmond Hervé and Georgina

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<sup>8</sup> Taintedblood.info, Accusations Documents, 2.

<sup>9</sup> AM Farrell, ‘Contaminated blood, A Comparative Study of Policy-Making Arising out of HIV Contamination of the Blood Supply in France, the United Kingdom and Ireland’ (Ph.D. thesis, University of Manchester 2004) 14; European Centre for the Epidemiological Monitoring of AIDS (WHO-EC Collaborating Centre on AIDS) ‘Prevalence of HIV Infection among Haemophiliacs at 31<sup>st</sup> December 1992’ AIDS Surveillance in Europe Quarterly Report: No. 36:33, 31 December 1992; European Centre for Epidemiological Monitoring of AIDS (WHO-EC Collaborating Centre on AIDS) ‘Cumulative AIDS Cases by Country and Transmission Group reported by 31<sup>st</sup> December 1992’ AIDS Surveillance in Europe quarterly Report: No. 36:19, 31 December 1992.

<sup>10</sup> AM Farrell, above n9.

<sup>11</sup> *Tromperie sur les qualités substantielles d’un produit* is a type of deception in French criminal law. The use of this offence in the blood episode in France will be analysed in ch5, 125 and ch6, 162.

<sup>12</sup> L Greilsamer, *Le procès du sang contaminé* (Le Monde 1992) 304.

<sup>13</sup> Ibid; Crim. 22 juin 1994 in J Pradel (Dir.), *Sang et droit pénal: A propos du sang contaminé*, Travaux de l’Institut de Sciences Criminelles, vol XIV (Editions Cujas 1994) 173.

Dufoix, respectively Prime Minister, Health Secretary and Social Affairs Minister between 1984 and 1986, underwent a trial before the *Cour de Justice de la République* (CJR)<sup>14</sup> for *homicide involontaire* and *blessures involontaires*. Georgina Dufoix and Laurent Fabius were acquitted. Edmond Hervé was found guilty but given an absolute discharge. In 1993, the third set of proceedings began and some of the same persons who had been prosecuted in the first set in 1992, and 26 other medical civil servants and treating doctors were investigated by Marie-Odile Bertella-Geffroy<sup>15</sup> and prosecuted for different offences including *empoisonnement* (poisoning), *violences volontaires* (grievous bodily harm), *non-assistance à personne en danger* and *homicide involontaire*. In the end in 2003, the third set of proceedings was referred to the *Cour de Cassation*<sup>16</sup> which discharged all the accused.<sup>17</sup>

In England in 1987, victims of the contamination (represented by the UK Haemophilia Society) started lobbying members of the Parliament to obtain financial support for the harm caused.<sup>18</sup> In 1988, they demanded that a public inquiry be conducted on the contaminated blood episode.<sup>19</sup> In April 1989, 962 PWH brought civil proceedings to hold health authorities including the Department of Health (DH), Regional Health Authorities (RHAs) and the Central Blood Laboratory Authority to account for negligence and breach of statutory duty.<sup>20</sup> The claimants alleged that these authorities had failed to achieve self-sufficiency in blood products, to take appropriate donor screening measures and to undertake HIV-testing soon enough. The claimants also argued that the defendants had failed to make heat-treated

<sup>14</sup> The *Cour de Justice de la République* deals with criminal liability of members of the Government in France. It was created during the blood scandal in order to try the executive on criminal grounds. It replaced the *Haute Cour de Justice*; O Beaud, *Le sang contaminé* (Presses Universitaires de France 1999) 3.

<sup>15</sup> Marie-Odile Bertella-Geffroy was the *juge d'instruction* in the third set of criminal proceedings arising out of the HIV-contaminated blood scandal in France. She was interviewed as part of our empirical research conducted in Paris. Interview with Marie-Odile Bertella-Geffroy (Paris, France, 18 January 2011); See Ch1, 32.

<sup>16</sup> The *Cour de Cassation* is the highest court in the civil and criminal courts hierarchy in France. It deals with appeals lodged against lower criminal or civil courts, and looks at points of law only. It can quash or confirm a decision. When the lower court's judgement is quashed, another court of the same level in the hierarchy (tribunal or appeal court) will have to take into account the *Cour de Cassation*'s decision and follow it to make a final judgement. See

<[http://www.courdecassation.fr/institution\\_1/savoir\\_plus\\_institution\\_2845/presentation\\_cour\\_cassation\\_11982.html](http://www.courdecassation.fr/institution_1/savoir_plus_institution_2845/presentation_cour_cassation_11982.html)>.

<sup>17</sup> Crim 2 juill 1998, Bull Crim n° 211, JCP 1998 II 10132.

<sup>18</sup> Mr Justice Horace Krever, Commission of Inquiry on the Blood System in Canada, Final Report Vol 3, 1997, 939.

<sup>19</sup> Rt Hon Lord Archer of Sandwell QC, above n7 at 6.

<sup>20</sup> *HIV haemophiliac litigation* [1990] 41 BMLR 171.

products available early enough and they had knowingly provided foreign blood products which were at high risk of HIV-contamination.<sup>21</sup> In December 1990, the case was settled out of court.<sup>22</sup> Victims were also awarded ex gratia payments but the executive always denied liability. In 2008 (20 years after the victims' demands for an inquiry), an independent inquiry—thus not a formal public inquiry—was conducted by Lord Archer on the HIV and Hepatitis C contaminated blood episodes. The inquiry aimed to analyse the knowledge on HIV/AIDS and the decision-making process of health authorities at the time of the episode and to give recommendations to the DH to respond to victims' demands. The recommendations were only in part followed by the DH.<sup>23</sup>

It should be noted that the episode has been much more publicised in France but details on the role of the criminal law in the episode have not been explored. No comparative study has been made as yet on the level of moral culpability on the part of doctors and health officials in the HIV-contaminated blood episode in France and England. Existing studies analyse the responses made in each country to the contamination but do not make a comparative analysis of the level of culpability in the episode in both countries.<sup>24</sup> This chapter will be necessarily detailed in order to demonstrate that, contrary to common perceptions at the time, failures were broadly similar in both countries with one exception, and overall, health officials in England were as morally culpable as health officials in France in the episode.<sup>25</sup> The information provided in this chapter on the failure of blood authorities to respond appropriately to the contamination is inevitably fuller in relation to France than England as a number of contemporaneous inquiries and the several criminal proceedings generated a wealth of information never accessible in England. French documents used include the Lucas Report in 1991, Parliamentary reports conducted by the *Assemblée Nationale* and the *Sénat* in 1992 and 1993 as well as investigative files of the three sets of criminal proceedings in France. The episode was also much more mediated in France, as will be shown in the next chapter. In England, the Archer Inquiry provides the most fully developed information on the matter. It is also

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<sup>21</sup> 41 BMLR 171 at 177.

<sup>22</sup> Mr Justice Horace Krever, above n18 at 942.

<sup>23</sup> Haemophilia Society React to Government Response to The Archer Report, date unknown.

<sup>24</sup> M Setbon, *Pouvoirs contre sida* (Seuil 1993); AM Farrell, above n9 ; MA Hermitte, *Le sang et le droit: Essai sur la transfusion sanguine* (Seuil 1998).

<sup>25</sup> B Kriegel, 'La responsabilité politique et pénale dans l'affaire du sang contaminé' (2001-2) 12 *Journal International de Bioéthique* 59, 60-61.

worth noting that many documents on the contamination in England were lost.<sup>26</sup> Thus, information on the failure of English blood authorities to respond to the contamination is more limited, particularly regarding the responsibility of individual doctors and health officials. This chapter is necessarily descriptive in relation to the failures in the decision-making process of blood institutions in the episode in France and England as the substantive analysis of the use of the criminal process in the episode which will come in later chapters will use the information gathered in this chapter.

#### **4.2 Comparison of the Level of Knowledge on HIV/AIDS in France and England between 1981 and 1988**

This section compares knowledge of the risk of HIV-infection in blood products on the part of scientists, doctors and health officials in France and England at the time of the contamination (1981-1988)<sup>27</sup> to find out whether French blood authorities showed a greater level of culpability than English blood authorities. The question is whether in France, doctors and health officials knowingly or recklessly exposed victims to risk to a degree not applicable to their English counterparts. If it can be proven that French and English authorities had known of the risks of HIV-infection in blood products but for no good reason failed to stop the supply of these products, culpability on their part may be established.

In 1981, in France and England, scientists were aware of the fact that AIDS was a transmissible disease.<sup>28</sup> They had found similar symptoms in homosexual males: a loss of immune defences showed by Kaposi's sarcoma and pneumocystis pneumonia.<sup>29</sup> The first case of AIDS in a homosexual in England was reported in December 1981.<sup>30</sup> In 1982, scientists knew that AIDS affected people under 60 years old who had had no prior disease and who had never received previous treatment that

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<sup>26</sup> Rt Hon Lord Archer of Sandwell QC, above n7 at 67-74.

<sup>27</sup> This period was chosen as representing the most crucial period in the episode, from the time AIDS became known by scientists to the beginning of criminal proceedings in France.

<sup>28</sup> MV Ragni et al., 'Acquired Immunodeficiency like syndrome in two haemophiliacs' (1983) 321(8318) *The Lancet* 213; L Montagnier, above n7 at 44-45.

<sup>29</sup> Unknown author, 'Acquired Immunodeficiency Syndrome' (1983) 321(8317) *The Lancet* 162.

<sup>30</sup> Unknown author, 'Surveillance of the acquired immune deficiency syndrome in the United Kingdom, January 1982-July 1983' (1983) 287 *British Medical Journal* 407.

could have caused ‘immune depression’<sup>31</sup>, and that AIDS manifested itself by one or several infections, called opportunistic.<sup>32</sup> In 1982, there were reports in the United States (US) showing evidence that AIDS could be transmitted through blood.<sup>33</sup> The epidemic in 1982 had affected 750 people in the US, around 100 in Europe, and an undetermined number in Africa.<sup>34</sup> Victims were all young, had the same type of immunodeficiency (decrease in T-Lymphocytes), 75% were homosexual or bisexual.<sup>35</sup> The remaining 25% were heterosexual males or females, children, intravenous drug abusers, Haitians recently immigrated to the US, and PWH.<sup>36</sup>

In March 1983, the risk of HIV-infection through sexual contact was known by scientists worldwide.<sup>37</sup> *Annals of Internal Medicine* in March 1983 issued three articles reporting cases of AIDS in PWH.<sup>38</sup> At that time, 10 cases of AIDS had been reported in France and 6 cases of AIDS in the United Kingdom.<sup>39</sup> In April 1983, there were questions on the risk of contamination in FCs<sup>40, 41</sup> French scientists at the Pasteur institute in Paris (Professor Luc Montagnier’s team) were convinced that the AIDS agent could be a retrovirus.<sup>42</sup> At that time, Robert Gallo’s team in the US had described a retrovirus known as HTLV (Human T-Lymphotropic Virus).<sup>43</sup> Montagnier contacted Gallo to discuss the hypothesis of a link between AIDS and HTLV.<sup>44</sup> However, Montagnier had found a new retrovirus, different from HTLV.<sup>45</sup> On the 20<sup>th</sup> of May 1983, Gallo and Montagnier published articles on their findings in scientific journal *Science*.<sup>46</sup> In June 1983, Montagnier’s team had evidence that the virus they had found was associated to AIDS. They called it Lymphadenopathy

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<sup>31</sup> L Montagnier, above n7 at 46.

<sup>32</sup> Ibid.

<sup>33</sup> LB Leveton, HC Sox Jr, MA Stoto, *HIV and the Blood Supply* (Institute of Medicine 1995) 20.

<sup>34</sup> L Montagnier, above n7 at 46.

<sup>35</sup> Ibid 46-47.

<sup>36</sup> Ibid.

<sup>37</sup> AP Waterson, ‘Acquired Immune Deficiency Syndrome’ (1983) 286(6367) *British Medical Journal* 743.

<sup>38</sup> Unknown author, above n29.

<sup>39</sup> L Montagnier, above n7 at 48; Unknown author, above n30 at 407.

<sup>40</sup> FCs became available in England from the 1970s and were very well appreciated by PWH. Because of the rising demand for FCs, by 1984, the annual requirement of Factor VIII was 80M units; Rt Hon Lord Archer of Sandwell QC, above n7 at 15.

<sup>41</sup> Unknown author, above n29.

<sup>42</sup> L Montagnier, above n7 at 48.

<sup>43</sup> Ibid.

<sup>44</sup> Ibid.

<sup>45</sup> Ibid 55.

<sup>46</sup> Ibid 56.

Associated Virus (LAV).<sup>47</sup> By the end of July 1983, 14 cases of AIDS were reported to the Communicable Disease Surveillance Centre in England, of which one PWH who had received Factor VIII (FVIII) imported from the US.<sup>48</sup> In August 1983, an article in the *British Medical Journal* (BMJ) stated that ‘the risk from blood products, imported into Britain seems at present very small’.<sup>49</sup> Around the same time in France, Montagnier announced in the Pasteur Institute that his team had ‘enough elements to act and warn the executive and other scientists’.<sup>50</sup> Thus in August 1983, Montagnier wrote to the Director General of the CNTS, Director General of INSERM<sup>51</sup>, Director General of Health, and Director General of Research at the Ministry of Research.<sup>52</sup> He claimed that:

Recent results showed that a young man with Haemophilia who had AIDS was infected with LAV. The contamination was probably caused by factor concentrates which he had been treated with. This data [allowed] me to consider this virus potentially dangerous to human kind and to alert health authorities so that they [could] very rapidly develop means of diagnosis and prevention against this virus.<sup>53</sup>

Some of those who were to face criminal charges were thus alerted to the risk in August 1983. In England, at the same time, the transmission of AIDS through blood was reported in medical and scientific journals.<sup>54</sup> The fact that French officials were directly warned by scientists could explain the reason for criminal prosecutions in France, in particular those against ministers, but as will be shown this was not the main reason. Working completely separately from Montagnier, Professor Robert Gallo in the US had identified the virus as Human T-Lymphotropic Virus III (HTLV-

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<sup>47</sup> Ibid 57.

<sup>48</sup> Unknown author, above n30.

<sup>49</sup> Unknown author, above n30.

<sup>50</sup> L Montagnier, above n7 at 61.

<sup>51</sup> *Institut National de la Santé et de la Recherche Médicale* (National Institute of Health and Medical Research). INSERM is the only public body dedicated to research on human healthcare in France; Décret 83-975 du 10 novembre 1983 relatif à l’organisation et au fonctionnement de l’institut national de la santé et de la recherche médicale.

<sup>52</sup> J Ruffié, JC Sournia, *La transfusion sanguine* (Fayard 1996) 313.

<sup>53</sup> L Montagnier, above n7 at 61.

<sup>54</sup> Mr Justice Horace Krever, above n18 at 927.



III) in 1984. HTLV-III was officially recognised as the virus causing AIDS.<sup>55</sup> LAV/HTLV-III was later renamed Human Immunodeficiency Virus (HIV)<sup>56</sup>.

In 1984, during the International AIDS Conference in Atlanta, scientists explained that heating blood products, including FCs, would eliminate the virus. At the international congress of blood transfusion in Munich in July 1984, inactivation processes were presented, including heat-treatment.<sup>57</sup> In September 1984, an article in *The Lancet* reported that the AIDS agent could be transmissible through blood and blood products and explained the possible link between AIDS and HTLV-III.<sup>58</sup> In October 1984, the Center for Disease Control (CDC) issued a report in the Mortality and Morbidity Weekly Report (MMWR) which confirmed the efficacy of heat-treatment on the inactivation of HIV.<sup>59</sup> A French Parliamentary report nevertheless showed that at that time, doctors and scientists were not convinced that heat-treated FCs were completely safe and the report stated that the efficacy of heat-treatment of FCs was only demonstrated in February 1985.<sup>60</sup> In October 1984, the National Haemophilia Foundation in the USA recommended to Haemophilia doctors who used FCs to start using heat-treated FCs, even though effective protection against AIDS still had to be proven.<sup>61</sup> In December 1984, *The Lancet* issued an article on the risk of AIDS in PWH, stating that heat-treated blood products should be used to treat PWH.<sup>62</sup> Thus, in both countries measures against the contamination could have been taken from summer 1983 and heat-treatment of FCs should have been achieved from December 1984. It will be shown that HIV-testing was made compulsory in August 1985 in France and started in October 1985 in England. Heat-treatment of FCs started in June 1985 in both countries.

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<sup>55</sup> L Montagnier, above n7 at 68; M Setbon, above n24 at 52; AM Casteret, *L'affaire du sang* (La Découverte 1992) 67-69 ; Mr Justice Horace Krever, above n18 at 812-814.

<sup>56</sup> The rest of this chapter and the following chapters will only refer to HIV.

<sup>57</sup> M Lucas, Transfusion Sanguine et SIDA en 1985, Chronologie des faits et des décisions pour ce qui concerne les hémophiles, Inspection Générale des Affaires Sociales, Septembre 1991, 21.

<sup>58</sup> R Cheingsong-Popov et al., 'Prevalence of antibody to human T-Lymphotropic virus type III in AIDS and AIDS-risk patients in Britain' (1984) 324(8401) *The Lancet* 477.

<sup>59</sup> LB Leveton, HC Sox Jr, MA Stoto, above n33 at 258.

<sup>60</sup> J Sourdille, C Huriet, *La crise du système transfusionnel français*, Rapport de la commission d'enquête du Sénat (Economica 1992) 103-114.

<sup>61</sup> M Lucas, above n57 at 22.

<sup>62</sup> Unknown author, 'Blood Transfusion, Haemophilia and AIDS' (1984) 324(8417) *The Lancet* 1433; Mr Justice Horace Krever, above n18 at 936.

On the 9<sup>th</sup> of February 1985, the chairman of the Haemophilia Centre Directors Organisation (UKHCDO)<sup>63</sup> in England wrote to *The Lancet* claiming that ‘untreated FVIII of any type must be considered potentially to be infected with HTLV-III [HIV]’.<sup>64</sup> In June 1985, the chairman of the UKHCDO issued another article in the BMJ stating that ‘the safety of cryoprecipitate and unheated UK blood products with regard to HTLV-III infection can no longer be assumed’.<sup>65</sup> At that time in England, five cases of PWH infected with AIDS had been reported, and 44% of Haemophilia A patients and 6% of Haemophilia B patients had been reported HIV-positive.<sup>66</sup>

By 1989 in France, 45% of PWH had been contaminated with HIV.<sup>67</sup> In England, 44% of PWH were contaminated with HIV in 1989.<sup>68</sup> The World Haemophilia Federation claimed that in France, half of PWH had become contaminated before 1984/1985.<sup>69</sup> In 1989 in France, out of 2676 Haemophilia patients, 1200 were contaminated, 970 were HIV-positive, 152 had AIDS and 59 were dead.<sup>70</sup> France was one of the countries with the greatest number of HIV-contaminated blood recipients (excluding PWH).<sup>71</sup>

Thus, dates of knowledge on HIV/AIDS and the case for heat-treatment were broadly the same in both countries and so do not seem to indicate greater culpability in France than in England. The knowledge on HIV/AIDS of doctors and health officials at the time does not demonstrate by itself a culpable failure. However, it will be shown in the next sections that the failure to use the knowledge and take measures after the risk of contamination was known reached the threshold of recklessness and should engage the criminal law.

#### 4.3 Comparison of the Blood Supply Organisation of France and England

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<sup>63</sup> The UKHCDO was a voluntary association of Haemophilia doctors in charge of collecting, co-ordinating data, giving recommendations to the Government and other bodies on Haemophilia patients and their treatment; Rt Hon Lord Archer of Sandwell QC, above n7 at 11.

<sup>64</sup> Mr Justice Horace Krever, above n18 at 937.

<sup>65</sup> AL Bloom, CD Forbes, CR Rizza, ‘HTLV-III, Haemophilia and blood transfusion’ (1985) 290 *British Medical Journal* 1901; Mr Justice Horace Krever, above n18 at 938.

<sup>66</sup> Mr Justice Horace Krever, above n18 at 928.

<sup>67</sup> J Sourdille, C Huriet, above n60 at 19.

<sup>68</sup> Ibid.

<sup>69</sup> Ibid 18.

<sup>70</sup> Ibid 19.

<sup>71</sup> Ibid 21.

The running of national blood services in both countries showed inefficiency and disorganisation which I argue were nonetheless not morally culpable as health officials could not foresee that the disorganisation of the system would provide a platform for the contamination. The way in which blood services were run demonstrated poor management which is not a type of behaviour which should engage the criminal law as it did not reach the threshold of recklessness which involves a level of disregard.

A comparative analysis of the blood supply organisation in France and England at the time of the episode is crucial here because in both countries, the decentralisation of blood services 'had led to a lack of institutional and financial incentives for regional directors to engage in cooperative and coordinated policy-making on a national basis'.<sup>72</sup> According to Farrell, 'such an approach was essential for dealing effectively with the threat of HIV/AIDS, which recognised no regional or national boundaries'.<sup>73</sup>

The organisation of the blood supply in France and England was subject to criticisms. Several commentators claimed that indeed the decentralisation of the French blood supply organisation was one of the causes of the expansion of contamination in blood products because each centre had a great autonomy of power, and regulation was difficult to implement at a large level.<sup>74</sup> Similar allegations were made by English PWH in the *HIV Haemophiliacs Litigation* about the organisation of the blood supply in England.<sup>75</sup>

In France, blood donations were voluntary and unpaid.<sup>76</sup> Apart from the CNTS, around 150 blood centres were decentralised and spread all over the country.<sup>77</sup> There was at least one blood centre in each *département* (county).<sup>78</sup> Some were non-profit organisations; others were part of public hospitals.<sup>79</sup> They were placed under the supervision of the executive. The Health Minister, then Hervé (later charged with

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<sup>72</sup> AM Farrell, above n9 at 227.

<sup>73</sup> Ibid.

<sup>74</sup> L Greilsamer, above n12 at 8-9; C Bettati, *Responsables et coupables, Une affaire de sang* (Seuil 1993) 27-30; AM Casteret, above n55 at 24-30; J Ruffié, JC Sournia, above n52 at 316, 317.

<sup>75</sup> 41 BMLR 171 at 176.

<sup>76</sup> AM Casteret, above n55 at 20; MA Hermitte, above n24 at 129.

<sup>77</sup> M Setbon, above n24 at 76-80; Mr Justice Horace Krever, above n18 at 807-808.

<sup>78</sup> O Beaud, above n14 at 11.

<sup>79</sup> C Bettati, above n74 at 27; O Beaud, above n14 at 11 ; Mr Justice Horace Krever, above n18 at 807.

*homicide involontaire*), had the power to decide on technical and normative matters.<sup>80</sup> The Health Minister was in charge of regulating blood products prices and reimbursement by *Sécurité Sociale* (National Insurance).<sup>81</sup> The Health Minister could approve the set up of a blood centre and nominate blood centre directors.<sup>82</sup> The more day-to-day oversight of blood centres was carried out by the *Direction Générale de la Santé* (DGS) and the *Laboratoire National de la Santé* (LNS).<sup>83</sup> Roux (later charged with *non-assistance à personne en danger*), as head of the DGS, could intervene into blood centres' technical activity via circulars on issues like prices and policies, although he was said to lack authority to enforce them.<sup>84</sup> Starr argued that 'whatever policies he formulated were largely at the behest of [...] blood bankers'.<sup>85</sup> This was demonstrated by his circular on 20 June 1983 (see below). The LNS, directed by Netter (later charged with *non-assistance à personne en danger*), was in charge of regulating the licensing of drugs and medical devices, including registering HIV tests.<sup>86</sup>

Among blood centres, seven centres were in charge of plasma fractionation and produced FCs.<sup>87</sup> The CNTS, run by Doctor Michel Garetta (later jailed for *tromperie*), did not have authority over other blood centres but it had a monopoly on plasma fractionation and drying for around 40% of French territory, which represented 45% of the total population of France.<sup>88</sup> Thus, blood centres in the Paris region and the West, were supplied in FCs by the CNTS.<sup>89</sup> The CNTS also had a monopoly on clotting factors imports.<sup>90</sup> The CNTS had the role of advisor to the Health minister.<sup>91</sup> It was shown in the investigations conducted in the first set of proceedings that Garetta's main interest was profit rather than blood safety.<sup>92</sup> He took an entrepreneurial approach to supplying blood and focused on expanding the

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<sup>80</sup> L Greilsamer, above n12 at 27.

<sup>81</sup> Ibid.

<sup>82</sup> M Lucas, above n57 at 5.

<sup>83</sup> C Bettati, above n74 at 27; L Greilsamer, above n12 at 27-29.

<sup>84</sup> D Starr, *Blood: An Epic History of Medicine and Commerce* (Harper Collins 1998) 288.

<sup>85</sup> Ibid.

<sup>86</sup> L Greilsamer, above n12 at 28-29, 78.

<sup>87</sup> M Lucas, above n57 at 5; L Greilsamer, above n12 at 25.

<sup>88</sup> C Bettati, above n74 at 27-28; L Greilsamer, above n12 at 25.

<sup>89</sup> L Greilsamer, above n12 at 25.

<sup>90</sup> Ibid 24.

<sup>91</sup> Ibid 25.

<sup>92</sup> Ibid 66.

market for the manufacture and supply of FCs within and beyond the country.<sup>93</sup> The approach took by Garetta demonstrated poor management and even though provided a framework for further negligence to be committed, did not reach the threshold of recklessness and could thus not be considered criminal because he could not foresee that the way in which he managed the CNTS would eventually lead to a massive contamination of the blood supply.

Within the CNTS, the department of research and development on blood products (including FCs) was the scientific advisor to the CNTS.<sup>94</sup> It was directed by Dr Jean-Pierre Allain later jailed for *tromperie*. The blood supply organisation in France relied on advisory bodies such as the *Commission consultative de transfusion sanguine* (CCTS). The CCTS was in charge of advising the Government on blood issues such as price rates for the selling of blood products, directors' nominations and the rules of evaluation systems.<sup>95</sup> The director general of health, the director general of the LNS and the director general of the CNTS were members of the CCTS.<sup>96</sup>

The organisation of the blood supply was similar in England. In the 1980s in the United Kingdom, the blood supply was divided into two services: the National Blood Transfusion Service (NBTS) for England and Wales, and the Scottish National Blood Transfusion Service for Scotland and Northern Ireland.<sup>97</sup> The NBTS collected blood and plasma from voluntary and unpaid donors.<sup>98</sup> As French blood centres, the NBTS was said to be much decentralised.<sup>99</sup> They were 13 regional transfusion centres in England and Wales, and 5 in Scotland.<sup>100</sup> They were all supervised by the DH.<sup>101</sup> They were funded by RHAs, which were subsidised by the Health Ministry.<sup>102</sup> The institution in charge of plasma fractionation for the National Health Service (NHS) in

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<sup>93</sup> D Starr, above n84 at 307; Interview with A (Cambridge, United Kingdom, 3 February 2011) 3.

<sup>94</sup> L Greilsamer, above n12 at 68.

<sup>95</sup> M Setbon, above n24 at 78.

<sup>96</sup> L Greilsamer, above n12 at 30.

<sup>97</sup> The present study only focuses on the National Blood Transfusion Service (NBTS); Mr Justice Horace Krever, above n18 at 923; M Setbon, above n24 at 133.

<sup>98</sup> Mr Justice Horace Krever, above n18 at 923.

<sup>99</sup> M Setbon, above n24 at 134.

<sup>100</sup> Mr Justice Horace Krever, above n18 at 923.

<sup>101</sup> M Setbon, above n24 at 134.

<sup>102</sup> Ibid 135.

England was the Blood Products Laboratory (BPL)<sup>103</sup> which, as will be shown below (see 4.4), was inadequate to respond to PWH's demands for FCs.<sup>104</sup> The NBTS was said to be 'a fragmented and disorganised shambles'.<sup>105</sup> Blood bankers had a great deal of autonomy regarding policy-making on blood products because of a lack of a centralised structure for the blood supply organisation.<sup>106</sup>

As in France, the blood supply organisation in England had advisory bodies, particularly the Blood Transfusion Service Advisory Committee (BTSAC), which included for the most part blood bankers.<sup>107</sup> However, the efficiency of the BTSAC as an advisory body was not proven. As Cash stated, 'some may be aware and concerned at the infrequency with which the [DH] convenes its [BTSAC] and the indifferent quality of its business, whereas others will be bemused by the department of their staff to meetings of the committee where important decisions are made that have vital policy implications which are accepted by some regional health authorities, and not others'.<sup>108</sup> The Medicines Division in the DH was in charge of regulating medicines including the licensing of blood products.<sup>109</sup> But because of a lack of 'technical and administrative resources', there were delays in the licensing of blood products and the Division 'tended to place greater priority on fostering the economic interests of the industry'.<sup>110</sup>

Thus, the organisation of the blood supply was similar in France and England: blood centres were decentralised and financed (directly or indirectly) and supervised by the Health Ministry. The blood supply was disorganised and lacked a central coordinating structure. One of the consequences of the decentralisation of both French and English blood supply organisations was that achieving self-sufficiency in FCs was made difficult.<sup>111</sup> Because the blood supply organisation was mostly decentralised in both countries, the regulation of blood products in blood centres was

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<sup>103</sup> The Blood Products Laboratory was designed to develop and manufacture therapeutic products derived from human blood for England and Wales; Department of Health, *Self-Sufficiency in Blood Products in England and Wales, A Chronology from 1973 to 1991*, 2006, 4.

<sup>104</sup> AM Farrell, above n9 at 119.

<sup>105</sup> J Cash, 'The Blood Transfusion Service and the National Health Service' (1987) 295(6599) *British Medical Journal* 617

<sup>106</sup> AM Farrell, above n9 at 136.

<sup>107</sup> *Ibid* 124.

<sup>108</sup> J Cash, above n105 at 618.

<sup>109</sup> AM Farrell, above n9 at 125.

<sup>110</sup> *Ibid* 126.

<sup>111</sup> *Ibid* 123.

difficult to implement at a large level and thus each blood centre was rather independent. This was not a culpable failure in itself because health officials could not foresee that the way in which the national blood supply was organised could put patients at a higher risk of contamination.

#### **4.4 Comparison of Self-sufficiency Issues in France and England**

From the 1970s, French and English health authorities had aimed for self-sufficiency in FCs following the recommendations of the World Health Organisation and the Council of Europe. The aim was originally to avoid importing FCs which could be at risk of non-A-non-B Hepatitis from countries which allowed paid donations and thus to guarantee the safety of FCs.<sup>112</sup> However, in both countries, self-sufficiency was never achieved.

This issue was raised in later criminal investigations by blood victims in France. They claimed that authorities had knowingly imported contaminated blood products from foreign countries. In the *HIV Haemophiliac Litigation*, English plaintiffs claimed that the DH had failed to achieve self-sufficiency in blood products early enough, which increased the number of blood imports at risk of contamination.<sup>113</sup>

Three types of blood products were used to treat PWH in France and England in the 1980s: frozen cryoprecipitates, freeze-dried cryoprecipitates and FVIII and FIX concentrates.<sup>114</sup> There was a greater risk of contamination in FCs as they were made from large numbers of blood donations.<sup>115</sup> If one donor was infected, the whole pool could be contaminated. Cryoprecipitates, on the other hand, were said to be safer as they were made from smaller numbers of blood donations.<sup>116</sup> However, the use of FCs was said to be much easier for PWH as it provided them with a rapid treatment and the ability to enjoy activities that they were not allowed to enjoy when using cryoprecipitates.<sup>117</sup> Haemophilia patients claimed that they were able to have a

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<sup>112</sup> Mr Justice Horace Kever, above n18 at 815; Department of Health, above n103 at 1.

<sup>113</sup> 41 BMLR 171 at 176.

<sup>114</sup> L Greilsamer, above n12 at 21; Rt Hon Lord Archer of Sandwell QC, above n7 at 13.

<sup>115</sup> L Greilsamer, above n12 at 21.

<sup>116</sup> Ibid.

<sup>117</sup> Ibid 22; M Lucas, above n57 at 27; Rt Hon Lord Archer of Sandwell QC, above n7 at 14-15.

‘normal’ life with the use of FCs.<sup>118</sup> Consequently, in both countries, there was a growing demand from PWH for FVIII.<sup>119</sup>

In France, the purpose of CNTS’s monopoly on fractionation and imports was to improve the quality of FCs and to achieve self-sufficiency.<sup>120</sup> On 22 November 1984, Netter announced that France was self-sufficient in FVIII, although it was said that self-sufficiency had actually been achieved thanks to commercial imports of FCs (2/3 were imported from abroad).<sup>121</sup>

In England, the BPL was not producing sufficient FCs to supply demand (only 20% of England’s need in FCs) because it did not have adequate processing facilities and there was a risk of contamination of the blood supply, especially blood products coming from the US.<sup>122</sup> From 1975, departmental minutes showed that funds were allocated to increase the production of FVIII, and that it was claimed that the blood supply should become self-sufficient within 2 to 3 years.<sup>123</sup> In 1975, the DH granted half a million pounds to the NBTS to increase plasma production to permit England and Wales to become self-sufficient in FVIII by 1977.<sup>124</sup> The increased demand in FVIII in the late 1970s did not allow this to happen and the decision to develop a new fractionation plant at Elstree was made in 1979, even though Margaret Thatcher’s newly appointed government had showed little interest in achieving self-sufficiency.<sup>125</sup> On the 30<sup>th</sup> September 1980, at a meeting of the UKHCDO, £1M were authorised by Ministers to improve BPL facilities, the work was completed in July 1982.<sup>126</sup> Thus, the DH decided to give £1.3M to develop BPL facilities and £21M to build a new plant with a capacity to produce 100 million units of FVIII.<sup>127</sup> However, ‘the government kept slogging away at building’ this new fractionation plant, and it was not until 1987 that the construction was complete, and England much relied on

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<sup>118</sup> M Lucas, above n57 at 27; Rt Hon Lord Archer of Sandwell QC, above n7 at 14.

<sup>119</sup> AM Casteret, above n55; Rt Hon Lord Archer of Sandwell QC, above n7 at 15.

<sup>120</sup> M Lucas, above n57 at 6.

<sup>121</sup> Ibid 29.

<sup>122</sup> V Berridge, *AIDS in the UK: The Making of Policy. 1981-1994* (Oxford University Press 1996) 41; Rt Hon Lord Archer of Sandwell QC, above n7 at 26.

<sup>123</sup> Rt Hon Lord Archer of Sandwell QC, above n7 at 30-36.

<sup>124</sup> Department of Health, above n103 at 1; Unknown author, ‘Freeze-dried factor VIII concentrates and the NHS’ (1978) 2 *British Medical Journal*, 1451.

<sup>125</sup> S Garfield, *The End of Innocence: Britain in the Time of AIDS* (Faber and Faber 1995) 61; Department of Health, above n103 at 2; Rt Hon Lord Archer of Sandwell QC, above n7 at 38.

<sup>126</sup> Rt Hon Lord Archer of Sandwell QC, above n7 at 38.

<sup>127</sup> Department of Health, above n103 at 2; Mr Justice Horace Krever, above n18 at 924.



American imports.<sup>128</sup> England became almost self-sufficient in FVIII by the end of the 1980s, when the NHS was importing only 20% of FVIII used by PWH, but as France, it never became fully self-sufficient in FCs.<sup>129</sup> In March 1984, England was importing 2/3 of FVIII.<sup>130</sup>

In both countries, health authorities aimed for self-sufficiency of the blood supply from the 1970s and throughout the 1980s to avoid importing blood products at risk of HIV-contamination.<sup>131</sup> However, in both countries, self-sufficiency in FCs was never completely achieved until the 1990s and the blood supply relied greatly on imported commercial FCs at risk of HIV-contamination or contaminated with HIV. This was partly justified on financial grounds in both countries and thus shows that finance took preference over healthcare safety. Once again, the reluctance of authorities to allocate funds to plasma fractionation facilities demonstrated bad management which did not reach the threshold of recklessness and thus should not be considered criminal because health authorities in both countries were not aware of the fact that this reluctance to allocate funds to improve fractionating facilities and achieve self-sufficiency would cause a risk to blood safety.

## **4.5 Comparison of the Decision-Making Process of Health Authorities in the HIV Blood Contamination Episode in France and England**

### **4.5.1 Donor Screening and HIV-Testing**

When the risk of HIV-contamination in FCs became known from summer 1983, primary responses to the contamination in both countries were donor screening and HIV-testing to ensure the safety of blood products provided to patients. However, failure to achieve these two measures soon enough was observed in both countries and I will demonstrate that because health officials delayed HIV-testing for financial

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<sup>128</sup> D Starr, above n84 at 301.

<sup>129</sup> Mr Justice Horace Krever, above n18 at 924.

<sup>130</sup> Supraregional Haemophilia Reference Centre, Royal Free Hospital, London, 'Blood Products and their Problems', March 1984.

<sup>131</sup> Department of Health, above n103 at 1; Mr Justice Horace Krever, above n18 at 815.

reasons, they showed disregard to the health and safety of blood patients which reached the level of recklessness and should thus engage the criminal law.

### **Donor Screening**

The failure to take necessary measures to screen blood donors early enough was used as a ground for liability of Hervé in the second set of proceedings in France but not addressed in civil proceedings in England.<sup>132</sup> On 20 June 1983, in France, Roux issued the aforesaid circular to inform blood centres that the AIDS agent could be transmitted through blood.<sup>133</sup> The circular was ordering blood centres to identify risk donors: homosexuals or bisexuals with multiple partners, intravenous drug users, people from Haiti and equatorial Africa, and sexual partners of all these persons.<sup>134</sup> The circular also demanded donors who thought they were in the ‘people at risk’ category to restrain from donating blood.<sup>135</sup> In August 1983, the DGS enacted another circular in which PWH were added to the ‘people at risk’ category.<sup>136</sup> But it was later shown in a report sent by the DGS (Dr Brunet) to the CCTS in November 1984 that blood centres had not implemented the circulars properly.<sup>137</sup> Thus in January 1985, Roux issued another circular which provided that blood centres should closely implement the provisions of the initial circular; otherwise blood centres could be liable for not implementing the circular.<sup>138</sup> However, these circulars ‘never became rigorously enforced’.<sup>139</sup> Roux’s behaviour did not show any disregard to patient safety. He acted promptly but there was a lack of enforcement mechanism. Blood centres did not realise the scale of the danger. Secretary of State for Health Edmond Hervé was said to have failed to take effective measures for the implementation of Roux’s circular when he had the power to do so.<sup>140</sup> But no causal

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<sup>132</sup> Commission d’instruction de la CJR Arrêt portant renvoi devant la CJR, 17 juillet 1998, D6137, 85, 213.

<sup>133</sup> M Lucas, Annexe 5 : Ministère des affaires sociales et de la solidarité nationale, Secrétariat d’Etat chargé de la santé, Direction générale de la santé, *Circulaire relative à la prévention de l’éventuelle transmission du syndrome d’immunodépression acquise (SIDA) par la transfusion sanguine*, DGS/3B n° 569, 20 juin 1983.

<sup>134</sup> Ibid; L Greilsamer, above n12 at 36.

<sup>135</sup> M Lucas Annexe 5, above n133.

<sup>136</sup> Mr Justice Horace Krever, above n18 at 815.

<sup>137</sup> TGI de Paris, Ordonnance de transmission du dossier et des pièces à conviction au procureur général et de non lieu partiel, D20917, 154; M Lucas, above n57 at 24.

<sup>138</sup> M Lucas, above n57 at 33.

<sup>139</sup> D Starr, above n84 at 289.

<sup>140</sup> Commission d’instruction de la CJR, above n132 at 213.

link was found between Hervé's negligence and the victims' death.<sup>141</sup> Even though Hervé had the power to implement the circular, he was not necessarily aware of the fact that the circular was not being applied.

In September 1983, so three months after Roux's circular, the DH in England issued the first pamphlet which contained guidelines for blood centres on the exclusion of high risk donors.<sup>142</sup> It was entitled 'AIDS and How It Concerns Blood Donors'.<sup>143</sup> Persons at risk of HIV-contamination were listed and asked not to donate blood.<sup>144</sup> People at risk were homosexual men with many sexual partners, intravenous drug users and people who had had sexual contacts with persons suffering from AIDS.<sup>145</sup> In January 1985, a second pamphlet was published and a circular was sent to RHAs, stating that it was 'essential that the revised leaflet be brought to the attention of each donor on an individual basis'.<sup>146</sup> It included as people at risk of HIV-infection people who were bisexual or homosexual even on an occasional basis.<sup>147</sup> Following these, 3 other leaflets were issued between August 1985 and July 1987, which were based on the second one but were updated according to scientific knowledge at the time.<sup>148</sup> The information given to donors was considered insufficient and inappropriate by some regional blood centres directors because they argued that all HIV-positive people were not necessarily detected.<sup>149</sup> English authorities did not demonstrate moral culpability either as they acted as promptly as they could.

In both countries, donor screening was done on a voluntary basis. The difference was that in France, the screening was done by doctors and in England it was done by donors themselves. This raised the question of efficacy of the screening. Although it seems that screening should have been more efficient when done by doctors, it had to be implemented properly, and yet, it was shown that the first two circulars were not implemented properly by blood centres in France. The efficiency of screening in England was not assessed. Hence, donor screening in both countries was achieved through instruments and procedure available at the time of the contamination. The

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<sup>141</sup> Cour de Justice de la République, arrêt 9 mars 1999, affaire n° 99-001, 20.

<sup>142</sup> Mr Justice Horace Krever, above n18 at 929.

<sup>143</sup> Ibid.

<sup>144</sup> Ibid.

<sup>145</sup> Ibid.

<sup>146</sup> Ibid.

<sup>147</sup> M Setbon, above n24 at 140.

<sup>148</sup> Ibid 140-141; Mr Justice Horace Krever, above n18 at 230-231.

<sup>149</sup> M Setbon, above n24 at 140-141.

process of screening was not a 100% efficient and not always realised properly. This however does not help to establish culpability on the part of French and English doctors and officials.

## HIV-Testing

When laboratories started manufacturing HIV-tests, the next step in HIV-screening was in France and England the screening of blood donations and the issue was to get reliable HIV-test kits to start the screening.<sup>150</sup> Failures to implement HIV-testing soon enough were demonstrated in both France and England. The failure to set up an HIV-test earlier on was used as a ground for criminal liability of health officials in France and civil liability of health authorities in England.<sup>151</sup> Netter was convicted of *non-assistance à personne en danger* for having failed to authorise HIV-testing early enough.<sup>152</sup> Fabius, Dufoix and Hervé were prosecuted for *homicide involontaire* in part because they had negligently delayed HIV-testing.<sup>153</sup> So in both countries, health officials had failed to set up HIV-testing early enough but only in France this failure gave rise to prosecutions of health officials and ministers.

On the 8<sup>th</sup> of February 1985, the American firm Abbott sent the LNS a file on its HIV-test for blood donors.<sup>154</sup> Abbott claimed that there were enough HIV-test kits to supply French blood centres.<sup>155</sup> In February 1985, the French company Diagnostics-Pasteur (DP) also presented the LNS with a file on its own HIV-test, but said that there would not be enough HIV-tests before early 1986.<sup>156</sup> On the 25<sup>th</sup> of February 1985, Dr Leblanc (Secretary of State for Health) addressed a note to Netter stating that Abbott's file was 'poor' compared to DP's study on its HIV-test.<sup>157</sup> On the 27<sup>th</sup> of February 1985, Netter contacted Roux to inform him that he agreed with Leblanc's note and affirmed that the registration of Abbott's test should be

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<sup>150</sup> Ibid 168.

<sup>151</sup> 41 BMLR 171 at 177.

<sup>152</sup> L Greilsamer, above n12 at 79.

<sup>153</sup> O Beaud, above n14 at 62-63.

<sup>154</sup> M Lucas, above n57 at 34.

<sup>155</sup> Ibid.

<sup>156</sup> Ibid.

<sup>157</sup> M Lucas, Annexe 8 A Leblanc (Ministère des affaires sociales et de la solidarité nationale Secrétariat d'Etat à la santé), note pour Monsieur le Directeur Général du Laboratoire National de la Santé, 25 février 1985.

delayed.<sup>158</sup> In March 1985, Abbott Laboratory's HIV test kits were approved for use in the US, but were considered unreliable by French authorities who also wanted to make sure that DP had a privileged market position regarding HIV testing.<sup>159</sup> On the 15<sup>th</sup> of March 1985, Netter addressed another note to Roux, highlighting the fact that HIV-testing would cost a great amount of money to the state.<sup>160</sup> On the 18<sup>th</sup> of March 1985, Weber (Director General of Pasteur, later charged with *homicide involontaire*) wrote to Leblanc to announce that a study on DP's test showed that the test was reliable and proposed to fix its price at 23 Francs.<sup>161</sup> An interdepartmental meeting on the 9<sup>th</sup> May 1985 presided by Mr Gros (scientific advisor to the Prime Minister, later charged with *homicide involontaire*) posed the question of whether or not to test every blood donation, stating that this measure would have to be supported by *Sécurité Sociale*, and evaluating the cost of this measure between 200M and 400M Francs. The meeting also addressed the question of DP's position on the market, claiming that Abbott's test had better chances to be adopted by French blood centres because it cost half the price of DP's test.<sup>162</sup> Three interdepartmental meetings on the 12, 17 and 22 July 1985 concluded that the price of DP's HIV-test should be fixed in a way that would allow DP to have 35% of the national market.<sup>163</sup> On 23 July 1985, Dufoix made HIV-testing compulsory for every blood donation from the 1<sup>st</sup> of August 1985.<sup>164</sup> In France, HIV-testing gave rise to great debates on the reliability of Pasteur and US companies Abbott, Travenol-Hyland and Organon screening tests

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<sup>158</sup> M Lucas, Annexe 9 R Netter (Laboratoire National de la Santé) Note pour Monsieur le Directeur General de la Santé, 27 février 1985 (arrivé le 28).

<sup>159</sup> Unknown author, 'Sang contaminé : responsabilité politique et responsabilité pénale', *Le Point*, 25 juillet 1998, 32.

<sup>160</sup> M Lucas, Annexe 10 R Netter (LNS) Note pour Monsieur le Professeur Roux Directeur Général de la Santé, 14 Mars 1985 (arrivé le 15).

<sup>161</sup> M Lucas, Annexe 12 J Weber (Pasteur) Lettre à Monsieur le Secrétaire d'Etat chargé de la Santé, Ministère des affaires sociales et de la solidarité nationale, 18 mars 1985.

<sup>162</sup> M Lucas, Annexe 17 Secrétariat général du gouvernement, compte-rendu de la réunion interministérielle tenue le 9 mai 1985 sous la présidence de M. Gros (confidentiel), conseiller auprès du Premier Ministre, 17 mai 1985 (diffusé le 22).

<sup>163</sup> M Lucas, Annexe 26 Secrétariat général du gouvernement, compte-rendu de réunions interministérielles tenues les 12, 17 et 22 juillet 1985, sous la présidence de M. Calavia du cabinet du Premier Ministre, 23 juillet 1985 (diffusé le 25).

<sup>164</sup> M Lucas, Annexe 24 Arrêté du 23 Juillet 1985 modifiant l'arrêté du 17 mai 1975 relatif aux prélèvements de sang, Journal Officiel du 24 Juillet 1985; Mr Justice Horace Krever, above n16 at 823.

and on financial questions.<sup>165</sup> This was called by the media at the time '*la bataille des tests*' (tests battle).<sup>166</sup>

In England, the concern was also to evaluate screening tests which were on the market.<sup>167</sup> Because of the decentralised nature of the blood supply organisation, blood bankers had a great autonomy in the choice of HIV-test kits.<sup>168</sup> From June to September 1985, evaluations of screening tests were carried out.<sup>169</sup> In England, there was also reluctance to use the Abbott's test. Starr states that 'when Abbott Laboratories applied for a British licence in March 1985, their British competitor, the Burroughs-Wellcome, was lagging. That circumstance made the government's response to the Abbott test suspicious'.<sup>170</sup> In other words, they rejected Abbott to give priority to their local laboratory's test. Thus, the DH delayed the approval to the American test for another five months, as they claimed that it was unreliable.<sup>171</sup> On 1 August 1985 (when HIV-testing was made compulsory for every blood donation in France), the DH announced that the Organon and Wellcome tests were 'particularly suitable'.<sup>172</sup> In September 1985, all the evaluations for HIV-test kits were completed and the DH announced that testing would begin in mid-October 1985 in blood transfusion centres.<sup>173</sup> On 14 October 1985, the NHS began screening blood donations using Organon and Wellcome tests.<sup>174</sup> Thus HIV-testing was delayed until a specific test was found in the UK.<sup>175</sup> The Archer Inquiry states that HIV-testing proved to be a slow process and the practice of testing was different from one hospital or treatment centre to another.<sup>176</sup> Archer stated that 'there was no one moment when a conclusive breakthrough for reducing or eliminating AIDS was achieved'.<sup>177</sup> According to the Archer Inquiry report, even though an HIV-test was available at an earlier date, it was only licensed in the UK in October 1985, and all donations processed by the BPL were screened from June 1986, thus one year

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<sup>165</sup> J Sourdille, C Huriet above n60 at 84-96.

<sup>166</sup> D Marchetti, "La genèse médiatique du "scandale du sang contaminé"" in *Ethique, sida et société*. Rapport d'activité du Conseil national du sida (Paris : La Documentation Française Janvier 1993) 10.

<sup>167</sup> J Sourdille, C Huriet above n60 at 103.

<sup>168</sup> AM Farrell, above n9 at 136.

<sup>169</sup> Mr Justice Horace Krever, above n18 at 933-934.

<sup>170</sup> D Starr, above n84 at 301-302.

<sup>171</sup> Ibid 302.

<sup>172</sup> Mr Justice Horace Krever, above n18 at 933.

<sup>173</sup> Ibid 934.

<sup>174</sup> Ibid; V Berridge, above n122 at 486.

<sup>175</sup> Rt Hon Lord Archer of Sandwell QC, above n7 at 55.

<sup>176</sup> Ibid 58.

<sup>177</sup> Ibid 59.

later.<sup>178</sup> It was said that the delay in which England took to adopt a screening test ‘gave the British firm the chance to step into the business of producing diagnostic kits for AIDS, a market which could be worth 100-200 million pounds world-wide by the late 1980s and which is now dominated by the US companies, chiefly Abbott Laboratories’.<sup>179</sup> English authorities thus also demonstrated a level of disregard by giving priority to their local products when other tests were available more rapidly.

HIV-testing was made compulsory in August 1985 in France and started in October 1985 in England, so 2 months after France. In both countries, health authorities could have set up an HIV-test earlier but they did not because they wanted to give priority to the local market. Starr states that ‘like their British colleagues, the French had valid reason to proceed cautiously, since the Abbott test produced a slight false-positive rate that policy-makers had to consider. Unlike the British, however, the French left an unmistakable record of their motives’.<sup>180</sup> Thus, even though Abbott’s test was said to be unreliable, there was some evidence that French and English health authorities wanted to prioritise the local market and this led to huge delays in the implementation of HIV-testing. The failure of French and English health authorities to implement an HIV-test promptly when they could have done so shows recklessness as there is clear evidence that authorities wanted to promote local markets rather than healthcare safety. However, the fact that the relevant health authorities were reluctant to use notoriously unreliable HIV-tests could be used as a mitigating circumstance which could reduce their culpability.

#### **4.5.2 Heat-Treatment and Supply of Contaminated Blood Stocks**

As noted earlier, the necessity of heat-treating FCs was known from at least December 1984. The failure to heat-treat FCs early enough on the part of blood authorities in France and England had serious consequences on the number of PWH who would become infected with HIV. The comparison shows that in both countries, there was a failure to provide heat-treated products to PWH soon enough and to stop the supply of contaminated FCs to patients. In France, these failures led to the prosecution of doctors, health officials and ministers for *empoisonnement* and other

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<sup>178</sup> Ibid.

<sup>179</sup> D Starr, above n84 at 302.

<sup>180</sup> Ibid 311.

offences including *homicide involontaire*. The supply of contaminated FCs for a period of time after heat-treated FCs were available to blood centres was also invoked as a ground for liability against the DH by PWH in England in the civil litigation.<sup>181</sup>

In both countries, blood authorities had to evaluate heat-treated FCs from different firms. US firm Travenol-Hyland wrote to Garetta on the 10<sup>th</sup> May 1983 informing that it had manufactured heat-treated FVIII, called Hemofil T.<sup>182</sup> Travenol-Hyland claimed that, although heat-treatment did not guarantee the inactivation of the AIDS agent, it would increase patient safety.<sup>183</sup> Around the same time in France, other blood centres (Lille and Strasbourg) were manufacturing their own heat-treated products or were importing heat-treated products.<sup>184</sup> In May 1985, a report made by a study group directed by Dr Habibi from the CNTS (later prosecuted) and addressed to the CCTS stated that all CNTS blood ‘lots’ could be considered potentially contaminated.<sup>185</sup> The group’s report claimed that until heat-treated FCs were sufficient to meet national needs, the supply of potentially contaminated FCs could only be tolerated if there was no possibility to replace them by non-contaminated products.<sup>186</sup> The report recommended that during this ‘intermediate period’ where non-heat-treated products and heat-treated products were both supplied, emergency measures should be taken in order to provide to Haemophilia patients, especially LAV-negatives, FCs manufactured from LAV-negative donors or foreign heat-treated products.<sup>187</sup> On the 9<sup>th</sup> May 1985, Garetta wrote to Mrs Pierre (Ministry of Social Affairs) claiming that 50% of PWH in France were LAV-positive and that ‘it [had] now become absolutely urgent to stop the contamination’.<sup>188</sup> The distribution of heat-treated FVIII was planned for July 1985.<sup>189</sup> The letter also stated that financial consequences of this ‘emergency strategy’ would be major and cause a yield loss of 20% for FVIII and FIX. Garetta requested that sale prices should be

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<sup>181</sup> 41 BMLR 171 at 177.

<sup>182</sup> M Lucas, Annexe 4 Lettre de M. Cibault (Travenol) à Docteur Garetta, 10 mai 1983.

<sup>183</sup> Ibid.

<sup>184</sup> M Lucas, above n57 at 43; L Greilsamer, above n12 at 54.

<sup>185</sup> M Lucas, Annexe 15 Extrait du rapport établi à la demande de la commission consultative de la transfusion sanguine, pour préparer des décisions d’urgence (groupe présidé par le Dr Habibi), Mai 1985.

<sup>186</sup> Ibid.

<sup>187</sup> Ibid.

<sup>188</sup> M Lucas, Annexe 16 M Garetta (Centre national de transfusion sanguine), Lettre confidentielle à Mme Pierre (Ministère des affaires sociales et de la solidarité nationale), 9 mai 1985.

<sup>189</sup> Ibid.



readjusted or the CNTS should be compensated for the loss. Garetta claimed that this solution was ‘vital’ for the CNTS.<sup>190</sup> On 29 May 1985, at a CNTS meeting, Garetta announced that with 2 to 3 per mil HIV-positive donors and blood lots of 1000 litres (which represent 4000 to 5000 donors), ‘all [CNTS] lots [were] contaminated’.<sup>191</sup>

During the meeting, it was recommended that HIV-negative patients should imperatively be supplied with non contaminated products.<sup>192</sup> Health authorities were advised to either put an end to the supply of contaminated stocks and remove all contaminated blood stocks from the market—which would have major economic consequences—and replace these products with foreign FCs which could also be at risk, or not to remove contaminated stocks, ‘since heat-treated products [would] be soon supplied’.<sup>193</sup> Garetta concluded the meeting by stating that he would soon write to Netter to inform him of the CNTS’s position which would be to keep contaminated blood stocks and continue to supply contaminated FCs, arguing that ‘health officials should find a solution to the problem’.<sup>194</sup> The three interdepartmental meetings on the 12, 17 and 22 July 1985 came to the conclusion that the yield loss caused by heat-treatment would be compensated by the increase in the price of heat-treated FCs, which will represent an annual cost of 31M Francs.<sup>195</sup> A note of Garetta on the 3<sup>rd</sup> of July 1985 provided that non-heat-treated FCs should be supplied to HIV-positive patients, ‘until stocks are exhausted’.<sup>196</sup> A confidential note from the CNTS stated that the CNTS should ‘*attempt* to distribute non-heat-treated products to HIV-positive patients’.<sup>197</sup>

In 1987, a note addressed to Garetta reported that the last lot of non-heat-treated FVIII was last supplied on the 19 July 1985.<sup>198</sup> Laurent Fabius then announced that non-heat-treated FCs would not be reimbursed by *Sécurité Nationale* from 1<sup>st</sup>

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<sup>190</sup> Ibid.

<sup>191</sup> M Lucas Annexe 18, CNTS compte-rendu de la réunion du 29 mai 1985 sur l’attitude à adopter concernant les anti-LAV positif découverts durant la phase de validation du test ELAVIA et leur incidence sur les dérivés sanguins fabriqués, date illisible.

<sup>192</sup> Ibid.

<sup>193</sup> Ibid.

<sup>194</sup> Ibid.

<sup>195</sup> M Lucas, Annexe 26 above n163.

<sup>196</sup> M Lucas, Annexe 28 B Habibi (Centre National de transfusion sanguine) note à distribution Cabanel, distribution Saint-Antoine, Dr Ferrer Le Cœur, Dr Girard, Dr Vergoz. 3 juillet 1985.

<sup>197</sup> M Lucas, Annexe 29 Centre national de transfusion sanguine, Compte-rendu de réunion (confidentiel), 23 août 1985.

<sup>198</sup> M Lucas Annexe 30 B Poupot (CNTS), note interne à M Garetta, 30 décembre 1987 (arrivé le 31)

October 1985.<sup>199</sup> In the first set of criminal proceedings in France, it was found that Garetta was directly involved in the decision to delay the prohibition of non-heat-treated FCs to the 1 October 1985 as he had mentioned that this measure would require bigger premises, which would have cost a significant amount of money.<sup>200</sup> Thus, culpability can be observed at two levels. First, national blood authorities were aware of the fact that the CNTS was supplying contaminated products because they did not have enough resources to heat-treat FCs. Blood authorities did not give the CNTS the means to heat-treat blood products and thus stop the supply of contaminated FCs. Second, CNTS officials, in particular Garetta, demonstrated an aspiration for preserving the CNTS's finance. While other blood centres already had their own heat-treated products, the CNTS was still supplying contaminated FCs.

From September 1983 in England, Haemophilia centres directors were informed of the types of heat-treated FVIII available for trial. They were those of Travenol Laboratories Inc., Armour Pharmaceutical Company, Miles Laboratories Inc., Alpha Therapeutic Corporation, Behringwerke AG and the NHS.<sup>201</sup> It was said that all these products except NHS FVIII were made from imports from the USA and could therefore be at risk of transmitting AIDS.<sup>202</sup> On the 19 November 1984, the BPL declared that it would begin heat-treating FCs by April 1985. NHS's heat-treated FVIII was said to give satisfactory yields. However, FIX free from HIV would have cost to the NHS between £2M and £3M a year.<sup>203</sup> Former Minister of Health Lord Owen declared very late in the day that the DH had 'failed to spend money allocated to stop the import of blood and blood products from abroad' but he claimed that he did not know about it at the time.<sup>204</sup> He also stated that 'there was resistance at the DH at the time to putting in the money'.<sup>205</sup> As an example, 'a batch of Australian-made Tuta blood bags with faults stretching from faulty seals to inadequate labelling was bought in defiance of local wishes just in order to save the NHS £700,000; a tiny

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<sup>199</sup> CJR Parquet Général, Réquisitoire définitif de non lieu, 11 juin 1998, D6132, 49.

<sup>200</sup> L Greilsamer, above n12 at 68.

<sup>201</sup> Oxford Haemophilia Centre, Trials of 'Hepatitis Reduced' Factor VIII-An update, 29 March 1984; Mr Justice Horace Krever, above n18 at 931.

<sup>202</sup> Oxford Haemophilia Centre, above n201.

<sup>203</sup> Research and Development department, Blood Products Laboratory, annual report, December 1984, 1.

<sup>204</sup> Unknown author, 'Haemophiliac HIV tragedy 'needless'', *BBC News*, 3 August 2001.

<sup>205</sup> *Ibid.*

fraction of its annual £32 billion budget'.<sup>206</sup> It was said that 'there is bound to be suspicion that the blood transfusion service is being run by accountants and penpushers rather than experienced medical professionals for whom the welfare of patients and donors has always come first'.<sup>207</sup> Archer also stated that 'it is difficult to avoid the conclusion that commercial interests took precedence over public health concerns'.<sup>208</sup>

Thus, English health authorities, just as French health authorities, were concerned over profit issues and heat-treating FCs cost a great amount of money. As in France, until spring 1985, doctors in England were reluctant to use heat-treated blood products because they claimed they were concerned over their safety and efficacy.<sup>209</sup> At the time, medical journals were giving conflicting advice, some claiming that heat-treated FCs were safe, others arguing that heat-treated FCs could be dangerous, which could cause difficulty in determining moral culpability.<sup>210</sup> England had started importing heat-treated FVIII from 1984 and heat-treated blood products were manufactured in England from April 1985. However, non heat-treated blood products were still supplied in certain transfusion centres until June or August 1985 (dates vary according to source).<sup>211</sup> Heat-treated FCs processed by the BPL were released from April 1987.<sup>212</sup> Imported heat-treated FCs were still used in England until 1988.<sup>213</sup> English blood products only became completely free from HIV from 1988.<sup>214</sup> Even after England started donor screening measures, blood stocks obtained from plasma collected before donor screening were not withdrawn because it would have caused a 'crisis of supply'.<sup>215</sup> It was shown that until 1986, England supplied a batch of heat-treated FVIII manufactured by Armour Pharmaceuticals from the United States named H.T. Factorate, which was contaminated with HIV.<sup>216</sup> In September 1986, health authorities discovered that two patients who had received

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<sup>206</sup> Unknown author, 'Blood scandal that cannot go unpunished', *Mail on Sunday* (London, July 9 1995).

<sup>207</sup> Ibid.

<sup>208</sup> G Katz, 'No Individual Blame in UK's Tainted Blood Scandal', *ABC News International*, 23 February 2009.

<sup>209</sup> J Sourdille, C Huriet, above n60 at 113.

<sup>210</sup> V Berridge, above n122 at 47.

<sup>211</sup> Mr Justice Horace Krever, above n18 at 932; M Setbon, above n24 at 153 ; J Sourdille, C Huriet above n60 at 128, 130; Rt Hon Lord Archer of Sandwell QC, above n7 at 45.

<sup>212</sup> Rt Hon Lord Archer of Sandwell QC, above n7 at 58.

<sup>213</sup> Ibid.

<sup>214</sup> Ibid 59.

<sup>215</sup> Ibid 52, 53.

<sup>216</sup> Mr Justice Horace Krever, above n18 at 932-933.

blood from this batch had seroconverted.<sup>217</sup> In October 1986, the batch was withdrawn from the market.<sup>218</sup>

French authorities were not more culpable than English authorities. Heat-treatment started around the same time in both countries. However, the supply of contaminated blood products continued in England after France had stopped supplying contaminated batches. There is evidence that heat-treatment could have been set up earlier and evidence that profit issues drove the decision-making process. When the efficacy of heat-treatment was known or at least the potential efficacy of heat-treatment was known, blood centres could have tried to make their own heat-treatment or another means to eliminate the virus. But at the time, they were still uncertain on the reliability of heat-treatment which makes it more difficult to establish moral culpability. Thus, the failure to heat-treat FCs soon enough could only be seen as gross negligence. However, there was evidence that French and English authorities knew that non-heat-treated FCs were at high risk of HIV-contamination and yet supplied contaminated stocks to patients. Rather than supplying contaminated FCs, authorities could have used cryoprecipitates which they knew were much safer. French and English health authorities thus chose to run an unacceptable risk to patient safety. This was a reckless failure which should engage the criminal law.

#### **4.5.3 Information to Patients**

The issue of informing patients about the risk of contamination with HIV of the FCs they were prescribed was determinant for PWH and blood recipients. The failure of doctors to inform their patients of the risk of contamination in FCs was a crucial issue in criminal proceedings in France and was discussed in the Archer Inquiry report which made recommendations to the DH to that effect.<sup>219</sup> Victims claimed that they were not informed of the risk of HIV-infection in FCs they were treated with until it was too late. They argued that if they had been informed, they would have chosen not to use the products and rely on other blood products such as cryoprecipitates, or they would have put pressure on health authorities to act on

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<sup>217</sup> Mr Justice Horace Krever, above n18 at 932-933; V Berridge, above n122 at 47.

<sup>218</sup> Ibid.

<sup>219</sup> See ch6, 187; Rt Hon Lord Archer of Sandwell QC, above n7 at 60.

screening, testing and heat-treatment.<sup>220</sup> In the first set of criminal proceedings in France, the use of the offence of *tromperie* (an offence with no English counterpart) partly aimed to show the failure to inform patients on the risk of contamination of the products that were supplied to them and I will seek to determine in Chapter 6 whether this offence was appropriate to use regarding this failure.<sup>221</sup> Doctors were also prosecuted for *empoisonnement* and *violences volontaires* in the third set of proceedings for failing to inform their patients on the risk of HIV-infection in FCs and for prescribing contaminated FCs to their patients.<sup>222</sup>

In France, the failure to inform patients led to the conviction of Drs Garetta and Allain for *tromperie* but in England, it was not even used as a ground for liability by plaintiffs in the civil litigation.<sup>223</sup> During the interdepartmental meeting of 9<sup>th</sup> May 1985, the French Secretary of State for Health declared that the *Comité National d’Ethique* (National Ethics Commission) had recommended that doctors should inform and advise patients tested HIV-positive in order to limit the spread of the virus among sexual partners.<sup>224</sup> Garetta and Allain had participated to *Comité National de l’Hémophilie* (CNH)<sup>225</sup> meeting on 19 June 1985 where they failed to inform the members that all blood lots were contaminated, although they knew that 10 to 50 PWH per month could get infected.<sup>226</sup> French Haemophilia patients were told about the risk of contamination only in the summer 1985.<sup>227</sup>

In England, the question of the information given to patients by doctors at the time of the contamination was addressed in the Archer Inquiry.<sup>228</sup> Lord Archer stated that in the 1970s and 1980s, patients were not informed about the risk of contamination of viruses through blood products and the risk of contamination of cryoprecipitates and FVIII.<sup>229</sup> The Inquiry also highlighted the fact that HIV-testing was often used

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<sup>220</sup> L Greilsamer, above n12 at 292; Réquisitions de Joseph Perfetti, Avocat général près la chambre criminelle de la cour de cassation in J Pradel (Dir.), *Sang et droit pénal. A propos du sang contaminé*, Travaux de l’Institut de sciences criminelles de Poitiers (Edition Cujas 1995) 117.

<sup>221</sup> L Greilsamer, above n12 at 71; See ch6 pt6.2.1, 161.

<sup>222</sup> TGI de Paris, above n137 at 26-28.

<sup>223</sup> 41 BMLR 171.

<sup>224</sup> M Lucas, Annexe 17 above n162.

<sup>225</sup> The CNH was in charge of centralising information, evaluating new treatments, and advising the CCTS on scientific and technical matters regarding Haemophilia. It included representatives of the AFH, the DGS and the LNS. L Greilsamer, above n12 at 30.

<sup>226</sup> L Greilsamer, above n12 at 67.

<sup>227</sup> Mr Justice Horace Krever, above n18 at 831.

<sup>228</sup> Rt Hon Lord Archer of Sandwell QC, above n7 at 60-67.

<sup>229</sup> Ibid 60.

without the patient's consent and tests results were either not passed on to patients or disclosed with inappropriate advice or no advice at all.<sup>230</sup> But Lord Archer also argued that at the time, information to patients was generally limited and transparency was not as good as it is today, acknowledging that if the episode had happened today, this failure to inform patients on the risk of HIV-contamination through blood products would be unacceptable.<sup>231</sup>

Thus, it seems that, considering the level of knowledge of doctors at the time of the contamination, their failure to inform the patients on the risk of infection would not have been considered as culpable in England. Another source shows that from 1985, transfusion recipients who were identified as being HIV-positive were advised by health professionals but this was not always effective since the process of identification was only done on a voluntary basis.<sup>232</sup> According to the *Sidaway* test for informed consent, if there was a significant risk to patient safety, the patient should have been informed of it.<sup>233</sup> However, the test allowed doctors to retain information if 'a reasonable medical assessment of the patient would have indicated to the doctor that disclosure would have posed a serious threat of psychological detriment to the patient'.<sup>234</sup> In the present case, the risk of HIV-contamination in FCs was known by doctors and scientists to be significantly high and it was in the interest of the patients as well as public safety to disclose the information on the risks of contamination in FCs. Thus, it seems that civil liability would have been established in England.

Doctors knew of the risk of contamination in FCs. There is evidence that giving patients information would have saved their life because knowing that FCs were contaminated, they could have asked to be treated with safer products such as cryoprecipitates. Instead, doctors did not inform them of the risk of contamination although they were in the capacity to do so and this amounted to recklessness and should have engaged the criminal law.

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<sup>230</sup> Ibid 61.

<sup>231</sup> Ibid 62-63.

<sup>232</sup> Mr Justice Horace Krever, above n18 at 938-939.

<sup>233</sup> *Sidaway v Board of Governors of the Bethlem Royal and the Maudsley Hospital* [1985] 1 All ER 643 at 654.

<sup>234</sup> Ibid.

#### 4.5.4 Collection of blood in prisons

So far I have shown that the flawed decision-making process in responding to the contamination was in most respects rather similar in both France and England. In this section, it will be demonstrated however that there was one substantial difference in the decision-making process which arguably suggests that French officials were more culpable than English officials. The failure to stop blood collection from prisons was used in the second set of proceedings against Hervé in France. He was said to have failed to take measures of implementation of the 20 June 1983 circular in prisons but no causal link was found and his liability was not established on this ground.<sup>235</sup>

In France, the high levels of contamination were also due to widespread prison collections of blood.<sup>236</sup> Even though from 1985, doctors and scientists had warned of the risk of HIV-infection of the blood collected in risk milieu, blood was still collected from prisons until the end of 1985 and the beginning of 1986.<sup>237</sup> June 1983 circular was not implemented in prisons.<sup>238</sup> Even when January 1985 circular was issued, Roux did not ban prison blood collections.<sup>239</sup> The reason for continuing collecting from prisons was that stopping it would have caused CNTS's deficit in profit.<sup>240</sup>

In England, there were no collections of blood in prisons. Thus, this was a grave error on the part of French authorities. French health officials knew from 1985 that blood collected from prison inmates was at high-risk of HIV-contamination. From that date, they should have stopped all collections of blood from prison but they chose not to for financial reasons. Thus, the failure to stop blood collections from prisons on the part of health officials and ministers when they knew of the high risk of HIV-contamination in prison was an obvious disregard to healthcare safety which amounted to recklessness. These actions did not lead to any conviction in France. This suggests that this difference was not a factor which influenced the use of the

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<sup>235</sup> Commission d'instruction de la CJR, above n132; CJR arrêt, above n141 at 20.

<sup>236</sup> Commission d'instruction de la CJR, above n132 at 88.

<sup>237</sup> J Ruffié, JC Sournia, above n52 at 314.

<sup>238</sup> Mr Justice Horace Krever, above n18 at 816.

<sup>239</sup> Ibid.

<sup>240</sup> Mr Justice Horace Krever, above n18 at 817.

criminal law in the blood episode but it is interesting to note that one of the worst actions of health officials in France did not lead to convictions.

#### **4.6 Conclusion**

This chapter has compared the level of culpability of French and English health institutions in their response to the HIV-contamination of the blood supply in the 1980s. The analysis was based on a comparison of specific areas of the decision-making process of French and English blood authorities from between 1981 and 1986, which were later to form the basis for criminal liability in France and claims relating to civil liability in England.

The comparative analysis revealed that in both countries, blood supply organisations were similar and demonstrated the lack of a centralised structure, which resulted in disorganisation and difficulty in implementing measures at a national level. French and English blood authorities failed to achieve self-sufficiency in FCs soon enough and as a result, blood centres had to rely on blood imports which were more at risk of HIV-contamination. Donor screening measures were undertaken around the same time in both countries but their efficiency was called into question.

Some failures in the episode in both countries were culpable failures which demonstrated a level of wilful disregard which could have fallen under the scope of the criminal law whilst others were a result of bad management and underestimation of the risk of contamination. HIV-testing was delayed in both countries until a reliable test was found, although it was shown that French and English health authorities also wanted to assist national businesses to have a top position on the market. Delays in adopting heat-treated FCs were also motivated by profit issues in both countries. In France and England, doctors wilfully failed to inform their patients fully on the risk of HIV-contamination in the products provided to them. French authorities acted more promptly than English authorities in some of their responses to the contamination.

Nevertheless, in France, there was a grave failure to stop blood collections from prisons, although health officials knew many inmates were HIV-positive. In England,



no such collections were recorded. This could offer the reason why the criminal law was used in France in the blood episode. However, the failure to stop blood collections from prison was only addressed in the second and third sets of proceedings and did not lead to any convictions, whereas the other failures stated above did. Thus, overall, France did not demonstrate a higher level of culpability than England. Therefore, we should ask: why did a similar level of culpability, which I argued, should have engaged the criminal law, not give rise to the use of criminal proceedings in England? In the next chapter, I suggest that features of French substantive criminal law and criminal procedure as discussed in Chapter 2, go a long way in explaining the use of criminal proceedings in the blood episode in France, when broadly similar culpable conduct resulted in no prosecutions in England.

## **5. Comparing the Role of Criminal Law and the Criminal Process in the HIV-Contaminated Blood Episode in France and England**

### **5.1 Introduction**

As explained in the previous chapter, no prosecutions were brought against doctors, health officials and politicians in England for failing to respond to the HIV-contamination of blood supply. Neither Margaret Thatcher (then Prime Minister), John Patten (then Minister for Health), John Moore (then Secretary of State for Social Services) nor directors of blood centres and the Blood Products Laboratory (BPL) nor prescribing doctors were held accountable or prosecuted for criminal offences. Yet, in France, the three sets of proceedings arising out of the episode involved prosecutions against ministers, senior health officials, blood centre directors and doctors. However, the vast majority of proceedings failed. I shall show in the next chapter that even though the prosecutions failed, lessons might be learnt from the use of the criminal process in the episode. In this chapter, I will illustrate how substantive criminal law and criminal procedure significantly affected the prosecutions of blood officials and doctors in France.

In the previous chapter, I have demonstrated that apart from blood collections in prison, failures in the decision-making process in France regarding the contamination did not demonstrate a higher level of moral culpability than in England and I argued that even in England some of these failures were in principle sufficiently morally blameworthy to be dealt with by the criminal law. However, in France, these failures led to the use of criminal proceedings, whereas in England, they only led to civil litigation which eventually ended in settlement. In this chapter, I suggest that because the level of culpability in France and England was similar and victims had the same grievances, the use of the criminal process was the result of distinctive features of French substantive criminal law and criminal procedure analysed in Chapters 2 and 3 as well as media coverage and the escalation of the scandal in France.

Even though social and political factors have been said to be major factors influencing the use of the criminal process in the blood episode in France<sup>1</sup>, I argue that substantive criminal law and criminal procedure were as significant, if not more so, than social factors in the use of the criminal process in the blood scandal in France. Following on from Chapter 2, I suggest that the wider range of negligence offences in France allowed for the use of criminal proceedings in the blood episode. However, some of the more ‘traditional’ intentional offences which only usually apply to ‘traditional’ criminals<sup>2</sup>, *tromperie*, *empoisonnement* and *violences volontaires* (assault), were also used to prosecute doctors and health officials. Whilst intentional offences provided for a broader arsenal for the prosecution of doctors and health officials in France, I will propose that factors related to criminal procedure as well as social and political factors influenced the use of these offences.

Following on from Chapter 3 on the role of French and English criminal procedures in healthcare malpractice, the involvement of *parties civiles* and *juges d’instruction* (JIs) in criminal trials involving negligent healthcare professionals and institutions greatly influenced criminal proceedings in the blood episode in France. Most prosecutions in France were initiated by victims and investigations were conducted by JIs. In England, victims could not initiate criminal prosecutions against blood officials or doctors and there were no investigating judges to ‘push’ prosecutions. I argue that the possibility to prosecute ministers for negligence offences and the heavy criticism of health authorities in the media went a long way in explaining the use of the criminal process in France in the blood episode.

Using doctrinal sources and the data collected from interviews conducted in Paris<sup>3</sup>, I will show that in France prosecutors were keener to prosecute in the blood episode than in ‘usual’ healthcare malpractice cases discussed in Chapter 3.

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<sup>1</sup> AM Farrell, ‘Contaminated Blood, A Comparative Study of Policy-Making Arising out of HIV Contamination of the Blood Supply in France, the United Kingdom and Ireland’ (Ph.D. thesis, University of Manchester 2004) 115.

<sup>2</sup> I use the terms ‘traditional criminals’ to describe individuals who have a guilty intent to harm or deceive others for their own benefit.

<sup>3</sup> See Ch1, 32.

## 5.2 The Role of Substantive Criminal Law in the HIV-Contaminated Blood Episode in France and England

In this section, I argue that the much broader range of criminal offences in French law allowed the use of criminal proceedings in the HIV-contaminated blood episode. Not only negligence offences discussed in Chapter 2, but also intentional offences which were used in the episode, were determinant. Although the range of intentional offences in France and England was similar, French offences were more specific and had a greater scope of application to the facts of the contamination episodes, especially the offence of *tromperie*.

### 5.2 Intentional Offences

#### *Tromperie* and Fraud Offences

In the previous chapter, I have shown that there was evidence of a high degree of negligence and disregard to the safety of blood patients in certain parts of the decision-making process in the blood episode in France.<sup>4</sup> It is notable that in the first set of criminal proceedings in France—proceedings which resulted in convictions—the charges were effectively of fraud, not of negligence. Drs Garetta and Allain were convicted of ‘*tromperie sur la marchandise avec la circonstance que le délit a eu pour conséquence de rendre l’utilisation de celle-ci dangereuse pour la santé de l’homme*’ (deception on merchandise with the aggravated circumstance that the use of the product was dangerous to human health).<sup>5</sup> They were accused of failing to stop the supply of contaminated blood products to Haemophilia patients and to inform them of the risk of contamination of the products that they were supplied with.<sup>6</sup> Thus, the courts held that they had deceived the patients on the substantial qualities of blood products. Garetta was sentenced to four years in prison and Allain was sentenced to four years in prison with two years suspended.<sup>7</sup> *Tromperie*, offence designed to criminalise fraud in the area of food retailing, was in part used to show

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<sup>4</sup> See Ch4.

<sup>5</sup> Crim. 22 juin 1994 in J Pradel (Dir.), *Sang et droit pénal: A propos du sang contaminé*, Travaux de l’Institut de Sciences Criminelles, vol XIV, Editions Cujas, 1994, 171; Article 1 Loi du 1er août 1905 sur les fraudes et falsifications en matière de produits ou de services; art L213-1 Code de la consommation.

<sup>6</sup> L Greilsamer, *Le procès du sang contaminé* (Le Monde Editions 1992) 67-71.

<sup>7</sup> Crim. 22 juin 1994, above n5 at 173.

that these failures were motivated by financial profit, which I have shown, was a recurrent issue in the blood episode in France.<sup>8</sup>

English health authorities had also failed to stop the supply of contaminated factor concentrates (FCs) and to inform patients on the risk of HIV-infection in FCs.<sup>9</sup> This failure was also due to profit issues and I established in Chapter 4 that this also demonstrated a disregard to the life of patients, which in principle may be sufficient to be punished by the criminal law. Could fraud offences have been used in the contaminated blood episode in England against, for example, the BPL's director and head of research?

In France *tromperie* does not take into consideration the motives for the deception. Deception would be established as long as the person had the intention to deceive, regardless of the motives (whether it is to obtain money transfer, pecuniary advantage or property).<sup>10</sup> In English criminal law, there is no direct equivalent of the offence of *tromperie* which is not only a product liability offence, but relates specifically to products dangerous for health.

In English criminal law at the time, the closest equivalents to *tromperie* were deception and fraud offences contained in the Theft Act 1968 and the Theft Act 1978 as well as criminal offences contained in the Consumer Protection Act 1987 (CPA 1987).<sup>11</sup> Section 15(4) of the Theft Act 1968 stated that deception 'means any deception (whether deliberate or reckless) by words or conduct as to fact or as to law, including deception as to the present intentions of the person using the deception or any other persons'.<sup>12</sup> Thus, deception could be express or implied. According to section 16 of the Theft Act 1968, a 'person who by any deception dishonestly obtain[ed] for *himself or another* any pecuniary advantage [should] on conviction on indictment be liable to imprisonment for a term not exceeding five years'.<sup>13</sup> There was however no intention on the part of doctors and health officials

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<sup>8</sup> L Greilsamer, above n6 at 16; See ch4; MA Hermitte, *Le sang et le droit. Essai sur la transfusion sanguine* (Seuil 1996) 374.

<sup>9</sup> See ch4 pt4.5.2, 112; ch4 pt4.5.3, 117.

<sup>10</sup> Art L213-1 Code de la consommation ; Loi du 1<sup>er</sup> Août 1905, above n5 ; L Greilsamer, above n6 at 67-71.

<sup>11</sup> Consumer Protection Act 1987 (CPA 1987) Part II s 12 (4); The CPA 1987 would only have been in force after the contamination episode but prosecutions offences under the CPA 1987 could have occurred from 1987.

<sup>12</sup> Theft Act 1968 s 15(4).

<sup>13</sup> Theft Act 1968 s 16.

to obtain gain or pecuniary advantage from patients so this could not have applied. Today, the Fraud Act 2006 is in force. Section 3 of the Fraud Act 2006 makes it a criminal offence to

(a) dishonestly [failing] to disclose to another person information which [one] is under a legal duty to disclose and (b) [intending], by failing to disclose the information (i) to make gain for [oneself] or for another, or (ii) to cause loss to another or to expose another to a risk of loss.<sup>14</sup>

This could have potentially applied to the failure to inform People with Haemophilia (PWH) of the contamination in FCs. However, once again, the Act requires that the failure be committed in order to obtain gain or cause loss to another, intention which could not be proven on the part of doctors and health officials in the blood case.

British health officials did fail to inform patients on the risk of contamination in FCs and continued to supply HIV-infected FCs to PWH even though they were aware of the risk of HIV-contamination but this failure was not committed with the aim of obtaining pecuniary advantage from them since products were provided on a non-for-profit basis. Thus, deception and fraud offences contained in the Theft Act 1968, the Theft Act 1978 and even now in the Fraud Act 2006, could not have applied against health officials in England.

Section 12 of the CPA 1987 contains the nearest equivalent to *tromperie* in English law by creating a 'product liability' offence. It provides that:

(4) where safety regulations require any person to give information to another for the purpose of enabling that other to exercise any function, that person shall be guilty of an offence if (b) (i) he makes any statement which he knows is false in a material particular; or (ii) he recklessly makes any statement which is false in a material particular.<sup>15</sup>

However, the Secretary of State must have made such regulations in relation to the product.<sup>16</sup> We should note that a civil product liability claim did eventually succeed

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<sup>14</sup> Fraud Act 2006 s 3.

<sup>15</sup> CPA 1987 Part II s 12 (4).

<sup>16</sup> CPA 1987 Part II s 11 (1).

in relation to Hepatitis C in England although criminal proceedings were not possible.<sup>17</sup>

In France, *tromperie* had a specific scope as it aimed to criminalise deception ‘on substantial qualities of a product’. It was similar to a product liability offence and showed the wider role of the criminal law in the protection of consumers in France as no special regulation was needed to use the offence of *tromperie*.

We should note that following the blood scandal, other healthcare scandals in France gave rise to the use of *tromperie*. For instance, in the Human Growth Hormone (HGH) scandal, doctors were prosecuted for *tromperie* and *homicide involontaire* for having prescribed and supplied vCJD<sup>18</sup>-contaminated HGH to patients.<sup>19</sup> Similarly, the heads of two French laboratories which supplied anti-Hepatitis B vaccine were prosecuted for *tromperie* for having supplied deficient vaccines.<sup>20</sup> Thus, the offence of *tromperie* seems to allow the criminalisation of certain kinds of healthcare malpractice because it contains elements of product liability.

There was not in England an offence equivalent to *tromperie* which could have been used in the blood episode to convict blood centre directors and health officials who concealed information. The fact that *tromperie* seems to be readily applicable to healthcare malpractice episodes such as the blood episode is one of the factors that explains the use of criminal proceedings in France. However, in the next chapter, I argue that *tromperie* was not a criminal offence appropriate to use in the HIV-contaminated blood episode as I will suggest that it was limited in giving a satisfactory response to both victims and doctors.

### ***Empoisonnement, Administration de substances nuisibles and Maliciously Administering Noxious Substances***

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<sup>17</sup> *A and other v National Blood Authority and Another* [2001] 3 All ER 289. To the best of my knowledge, no regulations were made in relation to blood products.

<sup>18</sup> Variant Creutzfeld-Jakob Disease.

<sup>19</sup> G Gaetner, ‘Le procès d’un scandale’, *L’express*, 6 février 2008.

<sup>20</sup> Unknown author, ‘Hépatite B: Deux grands laboratoires mis en examen pour ‘tromperie aggravée’’, *Libération*, 1 Février 2008.

In both countries, victims claimed that their relatives had been ‘murdered’ or poisoned following the blood episode.<sup>21</sup> An offence which generally applies to ‘traditional’<sup>22</sup> criminal cases, poisoning, was used in France arising out of the episode. *Empoisonnement* and *administration volontaire de substances nuisibles* were some of the initial charges proposed by victims in the first set of proceedings.<sup>23</sup> These offences were not used in the first set of proceedings as judges and prosecutors considered that they required intent to kill or harm. They argued that failures committed in the episode did not give evidence that the accused had the intention to kill or harm PWH.<sup>24</sup>

As we saw in Chapter 4, doctors and officials were charged with *empoisonnement* and *administration volontaire de substances nuisibles* in the third set of proceedings in France although those proceedings eventually failed. JI Bertella-Geffroy had *mis en examen*<sup>25</sup> doctors and health officials for *empoisonnement* for delaying HIV-testing, heat-treatment of FCs and the failure to stop the supply of HIV-contaminated FCs.<sup>26</sup>

*Administration volontaire de substances nuisibles* was similar to *empoisonnement* but the substance needed not be deadly.<sup>27</sup> At the time of the proceedings in the blood episode in France, *empoisonnement* was defined in article 301 of the old *Code Pénal* in France as ‘making an attack against the life of another by the use or administration of substances liable to cause death, more or less promptly, used or administered in any manner and regardless of the after-effect’.<sup>28</sup> *Administration de substances nuisibles* was defined in article 318 of the old *Code Pénal* as ‘causing to another a disease or an *incapacité totale de travail personnel* (ITTP)<sup>29</sup> by voluntarily administering, in any manner, substances which, without being liable to cause death,

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<sup>21</sup> C Dyer, ‘‘Murdered’ Aids victim’s fight goes on: Clare Dyer considers the painful death of a haemophiliac infected by imported blood’, *The Guardian* (London, 3 August 1990); L Greilsamer, above n6 at 18.

<sup>22</sup> See n2.

<sup>23</sup> L Greilsamer, above n6 at 18.

<sup>24</sup> Ibid.

<sup>25</sup> See ch3 n77, 73.

<sup>26</sup> TGI de Paris, Ordonnance de transmission du dossier et des pièces à conviction au procureur général et de non lieu partiel, D20917, 98.

<sup>27</sup> Ibid 22.

<sup>28</sup> Art 301 *Ancien Code Pénal* (ACP); MA Hermitte, above n8 at 397.

<sup>29</sup> See ch2 n48, 43.



are noxious to health'.<sup>30</sup> The offence of *administration volontaire de substances nuisibles* was a *crime* when it had caused an ITTP longer than twenty days, but was a *délit* otherwise.<sup>31</sup> In the blood episode, it applied as a *crime*.

It was shown in the previous chapter that similar failures were committed in England in health authorities and blood centres. Could a charge of poisoning have been laid here in England? The closest English equivalent of both *empoisonnement* and *administration volontaire de substances nuisibles* is the offence of maliciously administering noxious substances.<sup>32</sup> For the purposes of the analysis, I focus on the three offences altogether.

The French *Code Pénal* at the time of the proceedings did not specify that the offences required the intention to cause death or harm.<sup>33</sup> This is what allowed victims in France to lodge criminal complaints for *empoisonnement* in the first set and third set of proceedings since the old *Code Pénal* did not require proof of intention to kill or harm. However, the *Cour de Cassation* in 1998<sup>34</sup>, dealing with a case where a person had knowingly transmitted HIV to his partner through non protected sexual relations, held that it was not a case of *empoisonnement* because simply the fact that the person knew the 'administered substance was deadly' was not sufficient to constitute *empoisonnement*. Thus, *empoisonnement* and *administration de substances nuisibles* would from then on require the intention to cause death or harm and this is partly why these criminal proceedings arising out of the blood episode ultimately failed. Thus, proceedings for *empoisonnement* and *administration de substances nuisibles* might have been successful if the *Cour de Cassation* had not added the condition of intention. This concept of intention is further analysed in Chapter 6 in the determination of the proper role of the criminal law in this type of episode.

In England, sections 23 and 24 of the Offences Against the Person Act 1861 (OAPA 1861) define the offence of maliciously administering noxious substances as 'unlawfully and maliciously administer[ing] to or caus[ing] to be administered to or taken by any other person any poison or other destructive or noxious thing, so as

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<sup>30</sup> Art 318 ACP.

<sup>31</sup> Ibid.

<sup>32</sup> The Offences Against the Person Act 1861 (OAPA 1861) s 23, s 24.

<sup>33</sup> Art 318 ACP, 301 ACP.

<sup>34</sup> Crim. 2 juill. 1998, Bull. Crim. N° 211, JCP 1998 II 10132.

thereby to endanger the life of such person, or so as thereby to inflict upon such person any grievous bodily harm' (maximum sentence of ten years' imprisonment)<sup>35</sup> or 'with intent to injure, aggrieve, or annoy such person' (maximum sentence of five years' imprisonment)<sup>36</sup>. In *Kennedy (No 2)* (2005)<sup>37</sup>, the Court of Appeal held that the offence of maliciously administering noxious substances was committed by D, who gave a syringe of a drug to V, who injected himself with it. Although this may seem similar to the case of blood centres providing infected FCs to PWH, intention to cause harm on the part of doctors and health officials would have to be proven.<sup>38</sup>

Blood centres directors and other health officials had not authorised the production and distribution of contaminated blood products to their patients in order to endanger their lives or with intent to injure them. Thus, the outcome of criminal proceedings involving Haemophilia doctors and health officials for poisoning or maliciously administering noxious substances would have been much the same in France and England. The intention to kill or harm on the part of doctors and health officials could not be proven and the offence could not be used. The prosecution of doctors and health officials for *empoisonnement* and *administration de substances nuisibles* in the third set of proceedings was the result of a legal uncertainty in French criminal law at the time. Bertella-Geffroy who had conducted the investigations in the third set of proceedings claimed that the offences did not require intent prior the *Cour de Cassation*'s decision in 1998. I will argue in the next chapter that the facts of the scandal did not justify such charges as the offences of *empoisonnement* and *administration de substances nuisibles* should require the intention to kill or harm.

However, the fact that *empoisonnement* and *administration de substances nuisibles* were used to prosecute doctors and health officials in the blood episode in France, whereas maliciously administering noxious substances was not used in England, suggests that the use of the offences resulted from other factors, perhaps *parties*

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<sup>35</sup> OAPA 1861 s 23.

<sup>36</sup> OAPA 1861 s 24.

<sup>37</sup> *Kennedy* [2005] 2 Cr App R 23.

<sup>38</sup> It must be noted that the House of Lords quashed the Court of Appeal's decision. The House of Lords held that D had not caused the drug to be administered even though he may have encouraged or assisted the deceased to inject himself with it; See *R v Kennedy* [2007] UKHL 38. Although this gives an illustration of the type of cases sections 23-24 OAPA 1861 have been applied to, it supports the argument that the offence could not have been used in the blood episode. Nevertheless we should acknowledge that in *Kennedy*, the deceased had voluntarily injected himself with the drug.

*civiles*’ and *juges d’instruction*’s pressure to prosecute, and the media and greater public outrage in France (see 5.3).

### ***Violences Volontaires* and Causing Grievous Bodily Harm with Intent**

*Violences volontaires* was used in the third set of proceedings in France against doctors who had knowingly prescribed contaminated blood products to their patients but these proceedings also failed because the *Chambre d’accusation*<sup>39</sup> in 2001 decided that Marie-Odile Bertella-Geffroy had breached the rights to a fair trial (*droits de la défense*) by not notifying the accused of the change of offences.<sup>40</sup> The charges of *violences volontaires* were not subject to appeal. *Violences volontaires* are defined in the *Code Pénal* as any ‘act of violence causing an unintended death’, ‘...mutilation or permanent disability’.<sup>41</sup> The closest equivalent in English criminal law would be the offence of causing grievous bodily harm in section 18 of the OAPA 1861.<sup>42</sup> Section 18 makes it a crime to ‘unlawfully and maliciously by any means whatsoever wound or cause any grievous bodily harm to any person, with intent to do some grievous bodily harm to any person’.<sup>43</sup> The difference between *violences volontaires* and section 18 was that *violences volontaires* did not require the intention to cause harm. Someone may be prosecuted for *violences volontaires* as long as he had the intention to commit the act which caused the harm. On the other hand in England, section 18 requires intent to do grievous bodily harm. Thus, charges under section 18 would have been unlikely to succeed as intention to harm on the part of doctors and blood centres officials would have to be proven, which would have been difficult. However, section 20 of the OAPA 1861 includes the criminalisation of recklessly causing bodily harm, which I argue in the next subsection, could have been used in the blood episode.

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<sup>39</sup> The *Chambre de l’instruction* (then *chambre d’accusation*) is the appeal court for decisions of the JI. It analyses the case a second time after JI investigations and decides on whether to close the case, send it back to the JI or prosecute. B Boulloc, *Procédure Pénale* (23<sup>e</sup> edn, Dalloz 2012) 469-470, 811-814. The decision of the chambre de l’instruction can be appealed in the Cour de Cassation under certain conditions; Art 567 Code de Procédure Pénale (CPP); B Boulloc, above at 821-822.

<sup>40</sup> A Thoraval, ‘Nouveau retard en vue pour le procès du sang contaminé’, *Libération*, 3 mai 2001.

<sup>41</sup> Art 222-7CP; art 222-9 CP.

<sup>42</sup> OAPA 1861 s 18, s 20.

<sup>43</sup> OAPA 1861 s 18.

Intentional offences did not seem to apply to this context of failure, apart from *tromperie* which contained the very specific feature of a product liability offence and was related to damage done to health. Thus, the use of intentional offences may demonstrate that there was a greater public outrage in France, victims had the possibility to use the criminal process and JIs pushed the cases to prosecution.

### **5.2.2 Negligence Offences and Health and Safety Offences**

In Chapter 2, I have shown that the range of negligence offences in French criminal law helps to explain the greater use of criminal proceedings in healthcare malpractice generally.<sup>44</sup> I have also explained that although gross negligence manslaughter (GNM) is usually the only negligence offence used in the context of healthcare malpractice in England, there are other offences available which are roughly equivalent to the French offences in that area and which in theory could have been used in the HIV-contaminated blood episode. In this section, I aim to determine how these offences could have been used to convict doctors and health officials in the HIV-contaminated blood episode in England and why no prosecutions ensued.

#### ***Non-Assistance à Personne en Danger and Wilful Neglect***

The use of *non-assistance à personne en danger* in the HIV-contaminated blood episode in France led to two convictions. The closest equivalent that I found in England is wilful neglect, but it has a more limited scope as it only applies to mentally ill or incapacitated patients who are receiving care or treatment. It should be noted that a crucial difference between French and English criminal law is that there is no general duty to rescue in England whereas in France anyone could be liable for *non-assistance à personne en danger*.<sup>45</sup>

*Non-assistance à personne en danger* was used in the first set of criminal proceedings in France against Drs Netter and Roux and against prescribing doctors in the third set of proceedings.<sup>46</sup> In the first set of proceedings, Netter and Roux were

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<sup>44</sup> See Ch2 pt2.3, 42.

<sup>45</sup> See Ch2, 44.

<sup>46</sup> L Greilsamer, above n6 at 59.

prosecuted for *non-assistance à personne en danger* because, although they had the regulatory power, they had failed to prevent the supply of contaminated blood products and to take measures against the contamination.<sup>47</sup> They had failed to prevent the offence of *tromperie* from being committed by Allain and Garretta.<sup>48</sup> *Non-assistance à personne en danger* thus seems to be a powerful weapon against regulators. In the *Tribunal correctionnel*, Roux was convicted to a four year suspended sentence but Netter was acquitted as the tribunal held that he had acted reasonably and there was no evidence that he had wilfully abstained from preventing the commission of *tromperie*.<sup>49</sup> On appeal, Roux was convicted and sentenced to three years suspended and Netter was given a year suspended sentence.<sup>50</sup> The Court of Appeal's decision was confirmed by the *Cour de Cassation*.<sup>51</sup> In the third set of proceedings, *non-assistance à personne en danger* was used to prosecute Haemophilia doctors who had failed to inform their patients of the risk of contamination, when they knew the products they were using were contaminated, although these proceedings eventually collapsed because the *Cour de Cassation* in 2003 held that there was not enough evidence to convict doctors of *non-assistance à personne en danger*.<sup>52</sup>

*Non-assistance à personne danger* is defined as 'anyone who, being able without risk to himself or to third parties to prevent by immediate action a felony or a misdemeanour against the bodily integrity of a person, wilfully abstains from doing so'.<sup>53</sup> I will argue in the next chapter that this offence was much more appropriate than intentional offences to apply to failures occurred in the blood episode as well as for failures in the health service as a whole.

In England, there were also failures to stop the supply of contaminated FCs and failure to inform patients, as demonstrated in Chapter 4. As explained in Chapter 2, a distant equivalent to *non-assistance à personne en danger* is in English law the offence of wilful neglect contained in section 127 of the Mental Health Act 1983

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<sup>47</sup> Ibid 73-80.

<sup>48</sup> Ibid 81.

<sup>49</sup> Ibid 302.

<sup>50</sup> Crim. 22 juin 1994, above n5 at 173.

<sup>51</sup> Ibid.

<sup>52</sup> TGI de Paris, above n26 at 349.

<sup>53</sup> Art 223-6 CP (63 ACP).

(MHA 1983) and section 44 of the Mental Capacity Act 2005 (MCA 2005).<sup>54</sup> This offence could not have been used in the blood episode as it only applies to cases of ill-treatment or wilful neglect of any patient receiving care under the MHA 1983, or any patient who lacks mental capacity.<sup>55</sup> If the offence was widened to apply to all patients receiving care<sup>56</sup>, the use of wilful neglect could have been possible, as blood centre directors had knowingly failed to treat or provide proper treatment to PWH. However, even if the offence was expanded to apply to all patients receiving care, it most likely would have only applied to doctors directly providing care to blood patients and not health officials regulating the blood supply organisation. Thus, chances are low that wilful neglect could have applied in that case. In later chapters, I discuss whether England should adopt a general duty to rescue as part of criminal law.<sup>57</sup>

Hence, confirming the claims made in Chapter 2, the use of *non-assistance à personne en danger*, which has no direct equivalent in English criminal law and is often used in healthcare malpractice, permitted the use of criminal proceedings in the blood episode in France.

### ***Homicide Involontaire and GNM***

So far in examining the range of offences that were pursued within the criminal process in France, I have shown that prosecutions on analogous ground in England were nigh on impossible because, regardless of culpability, no comparative criminal offence existed in England. But in both countries, causing death by negligence can be a criminal offence and families of victims argued that this is what had happened in the episode.<sup>58</sup>

Criminal complaints were lodged for *homicide involontaire* in the first set of criminal proceedings in France but were not pursued by the JI.<sup>59</sup> *Homicide*

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<sup>54</sup> See ch2 pt 2.3.1, 42; MCA 2005 s 44; MHA 1983 s 127.

<sup>55</sup> N Allen, 'Psychiatric Care and Criminal Prosecution' in D Griffiths, A Sanders (eds), *Medicine, Crime and Society* (Cambridge University Press Forthcoming 2013) 159.

<sup>56</sup> A Alghrani et al., 'Health care scandals in the NHS: Crime and punishment' (2011) 37(4) *Journal of Medical Ethics* 230, 231.

<sup>57</sup> See ch7 pt7.2.4, 207; ch8 pt8.4, 248.

<sup>58</sup> See ch5 pt5.3.1, 140.

<sup>59</sup> L Greilsamer, above n6 at 17.

*involontaire* was charged against Fabius, Dufoix and Hervé in the second set of criminal proceedings. The ministers were said to have failed to enact proper regulation to guarantee the safety of blood products supplied to PWH and blood recipients, in particular regarding compulsory donor screening.<sup>60</sup> Hervé was convicted of *homicide involontaire* and *blessures involontaires* because the court held that he had the responsibility to implement proper regulation to ensure the safety of blood products.<sup>61</sup> He was nevertheless given an absolute discharge as the court considered that given the fact that the trial had taken place 15 years after the episode and 5 years after the prosecution, ‘numerous arguments had been conflicting, bringing charges on the action and responsibility of ministers, without any possible defense’.<sup>62</sup> The Court argued that ‘in such context, Edmond Hervé could not totally benefit from the presumption of innocence, by being subject, before trial, to excessive judgment, as it is too frequently the case for many other accused’.<sup>63</sup> The court considered that Hervé’s case had already been pre-judged by the public and the media and so, there was no fair trial.

In the third set of proceedings, health officials including Netter and Roux, were prosecuted for *homicide* and *blessures involontaires* for having delayed HIV-testing measures.<sup>64</sup> *Homicide involontaire* is defined in the *Code Pénal* as ‘causing the death of another person by clumsiness, negligence, carelessness, recklessness or breach of an obligation of safety or prudence imposed by statute or regulations’.<sup>65</sup> In England, since 1995, the requirements for GNM must be a breach of duty, which caused the victim’s death, and that breach of duty must be gross.<sup>66</sup> Given that many victims had died from the contamination, it seems that the most straightforward charge would have been to prosecute doctors and health officials for GNM in England.

In 2002/3, after demands from infected PWH for a criminal action, police investigations were conducted on the contaminated blood episode against health officials. But Crown Prosecution Service (CPS) legal experts affirmed that it would

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<sup>60</sup> Cour de justice de la République (CJR) arrêt 9 mars 1999, affaire n° 99-001, 17-20.

<sup>61</sup> Ibid 20.

<sup>62</sup> Ibid 20-21; F Gremy, ‘Contaminated Blood : the State’s renunciation and incompetence in the public health domain, a long tradition’ (2002) 14 *Santé Publique* 179-186.

<sup>63</sup> CJR arrêt 9 mars 1999, above n59 at 20-21; F Gremy, above n61 at 179-186.

<sup>64</sup> TGI de Paris, above n26 at 205-217.

<sup>65</sup> Art 221-6CP.

<sup>66</sup> *R v Adomako* [1995] 1 AC 171.

be impossible to prove culpability on the part of health officials.<sup>67</sup> Unfortunately, no further information on the CPS reasoning is accessible. It seems on the basis of this prosecution that the use of GNM was not possible in England.

Why was the use of *homicide involontaire* possible in France and the use of GNM not made possible in England? As proposed in Chapter 2, it could be that either *homicide involontaire* only required proof of simple negligence (even when the causal link was indirect at the time of the episode in France), or other factors influenced prosecutions for *homicide involontaire*. In the blood episode in France, most people charged with *homicide involontaire* had committed grave errors. Yet, in the previous chapter, I have argued that some of the failures committed by officials in England also demonstrated obvious disregard to the safety of blood patients. Obvious disregard at the level of recklessness would have been included in the requirements for GNM as it is more serious than what the definition of GNM requires for culpability. Causation and culpability could have been proven if in-depth inquiries had been conducted. However, GNM could only have applied to cases where victims had died and thus, would have excluded a number of victims from being able to access prosecution. Therefore, I argue in the next subsection that offences short of death were easier to use in the blood episode.

### ***Blessures Involontaires* and Causing Grievous Bodily Harm (GBH)**

The use of offences short of death had advantages over manslaughter, in particular it was easier to prove causation. *Blessures involontaires* was used in the second set of proceedings against ministers. Ministers were said to have delayed HIV-testing measures.<sup>68</sup> Hervé was convicted of *blessures involontaires* but he was given an absolute discharge for the reasons explained above.<sup>69</sup> In the third set of proceedings, health officials were prosecuted for *blessures involontaires* as they had delayed HIV-testing measures.<sup>70</sup> *Blessures involontaires* are defined in article 222-19 of the *Code Pénal* as the fact of ‘causing a total incapacity to work in excess of three months to

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<sup>67</sup> D Black, ‘Police drop ‘bad blood’ scandal’, *The Journal*, 7 July 2003.

<sup>68</sup> CJR arrêt 9 mars 1999 above n59 at 17-21.

<sup>69</sup> Ibid 22.

<sup>70</sup> TGI de Paris, above n26 at 205-217.



another person through clumsiness, negligence, carelessness, recklessness or violation of a safety or prudence obligation imposed by statutes or regulations'.<sup>71</sup>

The closest equivalent to *blessures involontaires* in English criminal law is recklessly causing grievous bodily harm (GBH) but it has not been used in cases of healthcare malpractice.<sup>72</sup> Section 20 of the OAPA 1861 provides that 'whoever shall unlawfully and maliciously wound or inflict any grievous bodily harm upon any other person, either with or without a weapon or instrument, shall be guilty of a misdemeanor'.<sup>73</sup> The House of Lords held that liability for reckless GBH did not require proof of an assault<sup>74</sup> and that the person had to foresee that his conduct would result in physical harm to another<sup>75</sup>. The offence was used in the context of people infecting their sexual partners with HIV. In *R v Dica*<sup>76</sup>, the Court of Appeal held that a person was reckless if, knowing that he is HIV-positive, he chose to have sexual intercourse with someone who was not aware of the infection. The wrongful conduct of a person failing to warn his partner that he was HIV-positive was very similar to the conduct of doctors and health officials failing to warn patients on the risk of contamination in blood products. The defendant was convicted of a charge of causing GBH for recklessly transmitting HIV to his successive partners through sexual intercourse.<sup>77</sup> As for *homicide involontaire*, *blessures involontaires* admits a wider scope for criminal liability, including cases of simple negligence, whereas section 20 of the OAPA 1861 requires proof of recklessness.

The HIV-contamination of blood products in France and England caused serious injury to patients as a result of contracting HIV. Section 20 could in theory have been used as a ground for liability of the supply of contaminated blood products for patients who had contracted AIDS as a result of blood products treatment, but recklessness on the part of doctors and health officials would have had to be proven. As shown in Chapter 4, some of the failures of health officials in the blood episode in both countries amounted to recklessness.

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<sup>71</sup> Art 222-19 CP.

<sup>72</sup> OAPA 1861 s 20.

<sup>73</sup> Ibid.

<sup>74</sup> *Wilson, Jenkins* [1984] AC 242.

<sup>75</sup> *Savage and Parmenter* [1992] AC 699.

<sup>76</sup> *R v Dica* [2004] 3 All ER 593 at 594.

<sup>77</sup> Ibid.

## **Health and Safety Offences**

As explained in Chapter 2, in England, under the Health and Safety at Work Act 1974 (HSWA 1974), employees at work who fail ‘to take reasonable care for the health and safety [...] of other persons who may be affected by [their] acts or omissions at work’ may be criminally liable.<sup>78</sup> Thus, blood centres officials could in theory have also been criminally liable for failing to provide reasonable care to Haemophilia patients at risk of HIV-contamination in FCs. The blood supply organisation could have been prosecuted for offences under the HSWA 1974. Offences under the *Code du travail* (Code of Work) in France are similar to offences under the HSWA 1974, but they apply to very specific cases in the area of work safety and are only punishable by a fine. This could not have applied to the blood episode.<sup>79</sup> This suggests that criminal procedure and social factors were the most influential in the use of criminal law in the blood episode because even though there were offences available in English law to prosecute the case, no effective prosecutions were launched in England.

The analysis of the role of substantive criminal law in the blood episode in France and England showed that the majority of the criminal offences used in France did not have a direct equivalent in England, even though I indicated a number of similarities. Differences in substantive criminal law were a significant factor in the use of criminal proceedings in France. English law simply offered a much more limited framework within which to consider the criminal liability of those whose failures resulted in so many patients contracting HIV from contaminated blood. However, in the event, most charges used in France did not lead to criminal convictions, which suggest that other factors influenced the initial resort to the criminal process, perhaps related to features of French criminal procedure.

### **5.3 The Role of Criminal Procedure in the HIV-Contaminated Blood Episode in France and England**

In the first part of this chapter, I have shown that even though the range of criminal offences used in the blood episode in France was greater than the range of equivalent

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<sup>78</sup> HSWA 1974 s 7(a), s 33(1)(a); See ch2, 50.

<sup>79</sup> Art L4741-1 Code du travail.

offences in England, certain negligence offences could have been used in England in the blood episode. Yet, as the abortive CPS investigation showed, the criminal process was barely even considered in England. Thus, it will be argued in this section that features of French criminal procedure also greatly influenced the use of criminal proceedings arising out of the scandal.

The role of victims as *parties civiles* and the role of the JIs in particular, as well as the role of the media and the public in the scandal, were major factors which pushed forward the use of criminal proceedings in France. Even though I have demonstrated in Chapter 3 that the *Ministère Public* (MP) was generally reluctant to prosecute cases of healthcare malpractice, it will be shown here that in the blood scandal in France, prosecutors were very ready to prosecute doctors and health officials, and I shall argue later that public and media pressure played a crucial role here. The possibility in France to prosecute ministers also explains the use of criminal proceedings, resulting from the ‘politicisation’ of the episode.<sup>80</sup>

### 5.3.1 Possibility for Victims to be *Parties Civiles* in France

Following the blood episode, victims of the contamination had the same grievances against health authorities in France and England. They claimed that they felt betrayed by doctors, and health officials could have acted earlier and more appropriately.<sup>81</sup> They sought closure, understanding and apologies from those allegedly responsible and some sort of retribution. However, French victims had the possibility to join civil claims for compensation to criminal complaints<sup>82</sup> whereas English victims did not.

It is generally agreed in the literature on the French blood scandal that the victims sought to use the criminal law to get compensation and explanations as well as to punish the persons who were allegedly negligent in the contamination.<sup>83</sup> The

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<sup>80</sup> Interview with Dominique Marchetti (Paris, France, 17 January 2011) 5.

<sup>81</sup> Rt Hon Lord Archer of Sandwell QC, Independent Public Inquiry Report on NHS Supplied Contaminated Blood and Blood Products, 23 February 2009, 104; C Bettati, *Responsables et coupables, Une affaire de sang* (Seuil 1993) 83; MA Hermitte, above n8 at 349.

<sup>82</sup> See Ch3 pt3.3, 66.

<sup>83</sup> L Schlageter, J Bouton, ‘L’affaire du sang contaminé en France et en Allemagne : contrôle, responsabilité et conséquences politiques d’un scandale de santé publique’ in C Bonah, E Lepicard, V Roelcke (Dir.), *La médecine expérimentale au tribunal, Implications éthiques de quelques procès*

literature mentions the victims' desire for punishment and even vengeance.<sup>84</sup> Victims felt betrayed by doctors and members of the executive. They felt that a conspiracy had been instigated against them by doctors and health institutions.<sup>85</sup> One PWH even lodged a complaint based on an allegation that the contamination represented a crime against humanity.<sup>86</sup> Victims argued that the executive and the CNTS had agreed to give priority to financial profit rather than patient safety, and around half of them were contaminated.<sup>87</sup> This motivated them to launch criminal proceedings for *tromperie* against Drs Garetta and Allain in the first set of proceedings. They claimed that they had been '*...trompés, depuis 1982, par silence et réticence, sur les qualités substantielles des produits sanguins qu'il [CNTS] délivrait, notamment sur l'aptitude à l'emploi, la corruption et les risques de complications inhérents à leur utilisation...*' ('deceived, since 1982, through silence and reluctance, on substantial qualities of blood products that [the CNTS] was providing, notably on the aptitude to use, the corruption, and the risks related to their use').<sup>88</sup>

However, some victims wanted doctors to be convicted of a *crime (empoisonnement)* and not simply a *délit*<sup>89</sup> (*tromperie*) so launched criminal proceedings against doctors and health officials for *empoisonnement*.<sup>90</sup> The use of *tromperie* and *empoisonnement* represented blood victims' demand for 'justice'. However, although victims might have seen the prosecutions of doctors, health officials and ministers as a positive, they were eventually very unhappy by the outcome of the processes, as will be demonstrated in Chapter 6.<sup>91</sup> However, they agreed that the unsuccessful proceedings were not totally pointless as they helped them understand the decision-making process in health authorities at the time of the episode.<sup>92</sup>

Like French victims, English victims argued that the criminal process was the only way to get justice. Victims argued that '[they] [saw] a criminal investigation as the

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*médicaux du XXe siècle européen* (Edition des archives contemporaines 2003) 336, 356; C Bettati, above n80 at 87; L Greilsamer, above n6 at 93; MA Hermitte, above n8 at 360.

<sup>84</sup> L Greilsamer, above n6 at 198.

<sup>85</sup> C Bettati, above n80 at 83; MA Hermitte, above n8 at 349.

<sup>86</sup> MA Hermitte, above n8 at 351.

<sup>87</sup> Ibid.

<sup>88</sup> L Greilsamer, above n6 at 16.

<sup>89</sup> *Crime* and *délit* are degrees of criminal offences in French law. See Ch2, 42.

<sup>90</sup> L Greilsamer, above n6 at 93.

<sup>91</sup> A Thoraval, 'Sang contaminé: vers la cassation', *Libération*, 8 juillet 2002.

<sup>92</sup> E Favereau, 'Le procès du sang contaminé. « C'est bidon, mais c'est couru d'avance ». Les associations de victimes, déçues, jugent cependant que le procès n'a pas été inutile', *Libération*, 10 mars 1999.

only route left open to [them]’.<sup>93</sup> They declared that ‘if [they] [could] get justice that way, which seem[ed] to be the only way, then [they] [were] willing to fight for it’.<sup>94</sup> The parents of a victim even said that their ‘son was murdered by treatment that was supposed to give him a better life’.<sup>95</sup> It was argued that ‘people really [didn’t] want the money, they [wanted] the truth and accountability and an assurance that whatever happened to them or their family [wouldn’t] happen to somebody else’.<sup>96</sup> More importantly, victims wanted that their situation be acknowledged, they wanted ‘closure’: ‘we will only be able to move on and truly live our lives when we know the truth has come out and everything possible has been done to address this catastrophe’.<sup>97</sup> Victims wanted ‘honest information’: ‘I’ve known people go on fighting for years because they believe they’ve been lied to. It’s the feeling that something’s being covered up that sends them to the law courts’, said former chairwoman of the Patient’s Association and lay member of the General Medical Council (GMC).<sup>98</sup>

Victims of the HIV-contamination of the blood supply in England had to use other means than the criminal law. They asked for financial compensation from the Department of Health (DH) as well as recognition of negligence committed by health authorities and a public inquiry, alleging that the DH had not screened blood donors or heat-treated FCs soon enough to stop the contamination.<sup>99</sup> Liability on the part of the DH was always denied and the DH always refused to conduct a public inquiry on the matter, which led Lord Archer to conduct an independent inquiry in 2009.<sup>100</sup>

The victims’ demand for compensation for the contamination was represented mainly by the UK Haemophilia Society which started lobbying Members of the Parliament in October 1987.<sup>101</sup> After getting the support of more than 200 Members of Parliaments, the Haemophilia Society asked the DH for financial compensation to

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<sup>93</sup> Unknown author, ‘Criminal probe into bad blood considered’, *The Journal*, 14 August 2002.

<sup>94</sup> Ibid.

<sup>95</sup> C Dyer, above n21.

<sup>96</sup> A Lloyd, ‘Law: When patients find insult is being added to injury; Gaining compensation for medical negligence is a major operation’, *The Independent* (London, 7 September 1990).

<sup>97</sup> Rt Hon Lord Archer of Sandwell QC, above n80 at 95-96.

<sup>98</sup> A Lloyd, above n95.

<sup>99</sup> C Dyer, ‘Appeal Court backs HIV blood victims’, *The Guardian*, 21 September 1990; Rt Hon Lord Archer of Sandwell QC, above n80 at 6.

<sup>100</sup> Rt Hon Lord Archer of Sandwell QC, above n80 at 6.

<sup>101</sup> Mr Justice Horace Krever, Commission of Inquiry on the Blood System in Canada, Final Report Vol 3, 1997, 939.

all HIV-infected PWH and their close family.<sup>102</sup> Health Minister Tony Newton responded to the demand by announcing that it would provide £10M to the HIV-contaminated PWH.<sup>103</sup> ‘It’s not just about the money. It’s about someone standing up and taking responsibility for what happened and about haemophiliacs being given the answers they need so we can move on with our lives’, said the chairwoman of the Haemophilia Action UK.<sup>104</sup> Thus, as well as claims for compensation by the Haemophilia Society, 962 PWH brought a civil action against the DH and other health authorities in 1989.<sup>105</sup> As mentioned in Chapter 4, the substance of their claims was very similar to those of French victims in criminal proceedings.

Thus, the question may be raised, since grounds for liability brought by victims were similar in criminal proceedings in France and in civil proceedings in England and, as I have shown in 5.2, the use of some criminal offences could have been possible in England (GNM, causing GBH), why was the use of the criminal process not made possible in England arising out of the episode?

In part it is simply that English law did not offer the means to victims to launch criminal proceedings as French law did. In France, being *parties civiles*<sup>106</sup>, victims had the right to propose criminal offences to the JI and the MP and thus launch the *Action Publique*.<sup>107</sup>

As mentioned in 5.2, victims played an important role in pressing for the prosecutions of doctors and health officials in the first and third sets of criminal proceedings in France.<sup>108</sup> In the second set of proceedings, victims could not be *parties civiles* in the CJR, thus they had no direct impact on the prosecution of ministers.<sup>109</sup> However, as will be seen later in the chapter, the second set was a result of the political scandal in France. In England, the only way victims could themselves

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<sup>102</sup> Ibid.

<sup>103</sup> J Carvel, ‘The Day In Politics: Old lobbying virtues win victory for AIDS case’, *The Guardian*, 17 November 1987.

<sup>104</sup> Unknown author, ‘Victory for the victims’, *The Journal*, 30 August 2003.

<sup>105</sup> See Ch4, 93.

<sup>106</sup> See Ch3 pt3.3, 66.

<sup>107</sup> Ibid.

<sup>108</sup> E Favereau, ‘Sang contaminé: vers un troisième procès’, *Libération*, 27 mars 2002.

<sup>109</sup> See ch5 pt5.3.4.

have used the criminal law was through the process of private prosecution which is very rare and expensive.<sup>110</sup>

It is worth noting that another factor that could have influenced the use of the criminal law as a response to the HIV-contaminated blood episode in France is the fact that before lodging criminal complaints, French victims tried to mobilise politicians to explain their struggle and ask for compensation but ministers never responded to their demands when at that time in England, victims had already received ex gratia payments after a lobbying campaign.<sup>111</sup> Perhaps victims in France lodged the first criminal complaints in 1988 because it was their only chance to be heard.<sup>112</sup>

It seems that French victims could be more proactive rather than waiting for the police and prosecutors to act as would have been the case in England. They had more opportunities to use the criminal process than in England, combined with a wider range of offences available to prosecute doctors and health officials. This was also emphasised by the scandal and the role of the media in France.<sup>113</sup>

### 5.3.2 Role of *Juges d'instruction* (JIs), Prosecutors and Judges

JIs have a major influence on criminal proceedings involving doctors in France.<sup>114</sup> In the blood episode, JIs had a considerable impact on prosecutions by receiving claims from the *parties civiles*, by conducting criminal investigations and by sending the accused to courts and proposing charges. JIs in France are generally very in favour of prosecuting 'bad' doctors.<sup>115</sup> Indeed, in criminal proceedings arising out of the contaminated blood episode in France, JIs were all in favour of the prosecution of

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<sup>110</sup> A Sanders, 'Victims' voices, victims' interests and criminal justice in the healthcare setting', in D Griffiths, A Sanders (eds), *Medicine, Crime and Society* (Cambridge University Press Forthcoming 2013) 125; C Van Den Wyngaert, *Criminal Procedure Systems in the European Community* (LexisNexis UK 1993) 96-97.

<sup>111</sup> AM Casteret, *L'affaire du sang* (La Découverte 1992) 208; Mr Justice Horace Kever, above n100 at 939.

<sup>112</sup> O Beaud, *Le sang contaminé, Essai critique sur la responsabilité des gouvernants* (Presses Universitaires de France 1999) 36; As we will see in ch6 pt6.3.6, 192, French victims however did eventually win compensation in 1991.

<sup>113</sup> See ch5 pt5.3.3.

<sup>114</sup> See ch3 pt3.4.1, 71.

<sup>115</sup> Ibid.

the accused and pushed forward the use of the criminal law against them.<sup>116</sup> In Chapter 3, I have also shown that French prosecutors were generally reluctant to prosecute ‘negligent’ doctors.<sup>117</sup> However, in the blood episode, the MP were sometimes keen to prosecute doctors and health officials.<sup>118</sup> I have argued that French judges are usually more willing than English juries to convict ‘negligent’ doctors. In this section however, I shall suggest that judges were more reluctant to convict in criminal proceedings arising out of the blood episode in France.

In the first set of proceedings, JI Sabine Foulon *mis en examen* Garetta, Allain, Netter and Roux for *tromperie* and *non-assistance à personne en danger*.<sup>119</sup> Following on Foulon’s proposal on charges, prosecutors then required the prosecution of the four doctors for these charges.<sup>120</sup> The four doctors were convicted.<sup>121</sup> It seems that without the help of the JI in the first set of proceedings victims would have had difficulty to ‘push’ their case to court. No reluctance from prosecutors or judges was recorded with regard to prosecuting and convicting the accused of *tromperie* in the first set of proceedings.<sup>122</sup> Thus JIs had a major role in the first set of proceedings, supported by the MP and followed by judges in court.

In the second set of proceedings, the *commission d’instruction* (investigating commission) in the CJR had a significant impact on the prosecution of ministers.<sup>123</sup> In the second set, however, prosecutors showed more reluctance to prosecute than in the first set. The *commission d’instruction* initially chose to prosecute the three ministers for being accessory to *empoisonnement*.<sup>124</sup> The *procureur général* (prosecutor general) requested that the case be dismissed as he claimed that given the circumstances and information provided to them, the ministers, despite some serious weaknesses for some (Dufoix and especially Hervé), had ‘acted reasonably as

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<sup>116</sup> L Greilsamer, above n6; TGI de Paris, above n26; Commission d’instruction de la CJR Arrêt portant renvoi devant la CJR, 17 juillet 1998, D6137.

<sup>117</sup> See ch3 pt3.5, 82.

<sup>118</sup> Interview with Marie-Odile Bertella-Geffroy (Paris, France, 18 January 2011) 3.

<sup>119</sup> L Greilsamer, above n6 at 13-81.

<sup>120</sup> Ibid 81.

<sup>121</sup> Crim. 22 juin 1994, above n5 at 188.

<sup>122</sup> L Greilsamer, above n6 at 81.

<sup>123</sup> D Simmonot, ‘Sang contaminé: la cour de justice poursuit son enquête. Mardi, le procureur avait souhaité un non-lieu pour les ministres’, *Libération*, 15 mars 1997; A Thoraval, ‘Les millions envolés de la transfusion sanguine. Le Parquet ne donne pas les moyens au juge Bertella-Geffroy de mener à bien une instruction vieille de sept ans’, *Libération*, 15 Septembre 1999.

<sup>124</sup> O Beaud, above n110 at 54.



expected in this type of situation'.<sup>125</sup> The *commission d'instruction* did not follow the prosecutor's *réquisitions* and ordered that investigations be continued as it possessed new documents provided by Bertella-Geffroy, who was investigating on the case of *empoisonnement* in the third set of proceedings at the same time.<sup>126</sup> Thus, the *commission d'instruction* showed a willingness to prosecute. Once again, the prosecutor required the case to be dismissed, claiming that the new documents confirmed his initial opinion.<sup>127</sup> The commission refused the dismissal again and decided to change the offence to *homicide involontaire* and *blessures involontaires*<sup>128</sup> and send the case to court.<sup>129</sup> This might suggest that the commission was willing to use any offence available to make it easier to prosecute ministers. Prosecutors seemed to have been reluctant to prosecute for a *crime*<sup>130</sup> such as *empoisonnement*. The three ministers thus underwent a trial in the CJR for *homicide involontaire* and *blessures involontaires*. Only Hervé was convicted but given absolute discharge. Judges in court seemed to be reluctant to convict ministers as the only conviction in this set of proceedings was pronounced with an absolute discharge. This may suggest that the criminal law was used here as a symbolic instrument to appease victims and the public. This leads us to revisit the role of the criminal law as a deterrent, punitive, or rehabilitative process. Once again in this set, *juges d'instruction* had a crucial role in the launching of proceedings. It has been suggested that the public outrage in France had a significant influence on the prosecution of ministers in the second set.<sup>131</sup>

Following the decision of the *Cour de Cassation* in 1994, other investigations started and were based on the charges of *empoisonnement* and so the third set began. JI Bertella-Geffroy played a crucial role in the proceedings for *empoisonnement*. She initially prosecuted and investigated 32 doctors and health officials (including Garetta, Allain, Netter and Roux) on the ground of *empoisonnement* and being accessory to *empoisonnement*.<sup>132</sup> Bertella-Geffroy noted that at first, the MP were in

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<sup>125</sup> Ibid 55.

<sup>126</sup> Ibid.

<sup>127</sup> Cour de Justice de la République Parquet Général, Réquisitoire définitif de non lieu, 11 juin 1998, D6132, 97 ; O Beaud, above n111 at 55.

<sup>128</sup> Art 319, 320 ACP (art 221-6, art 222-19 CP).

<sup>129</sup> Commission d'instruction, above n115 at 1.

<sup>130</sup> See Ch2, 42.

<sup>131</sup> O Beaud, above n111 at 48.

<sup>132</sup> TGI de Paris, above n26 at 1-6.

favour of prosecuting the accused.<sup>133</sup> But they considered that *empoisonnement* required the intention to cause death and could not apply to the case.<sup>134</sup> Even though the MP were against the use of *empoisonnement*, they were nevertheless in favour of a prosecution for other offences. Thus, they made *réquisitions* to prosecute for *administration de substances nuisibles* for victims who had not died and *homicide involontaire* for victims who had died.<sup>135</sup> Bertella argued that this reasoning was absurd as it would have meant that the offence was more serious for victims who had not died than for victims who had died.<sup>136</sup> So, she changed charges to other offences including *empoisonnement* for the most serious cases and *homicide involontaire*, *blessures involontaires*, *violences volontaires* and *non-assistance à personne en danger* for the rest.<sup>137</sup> The third set of proceedings did not go further following the *Chambre d'accusation*'s decision in 2001.<sup>138</sup> The *Cour de Cassation* in 2003 confirmed the decision of the *Chambre d'accusation* and held that *empoisonnement* required the intention to cause death and doctors and health officials had no intention to cause the death of their patients.<sup>139</sup>

In the third set of proceedings again, the JI played a determinant role in the prosecution of the accused. The MP also played a role and seemed to have been willing to prosecute the accused, although not for a *crime*. Judges did not show such willingness to convict. This seems to confirm the claims made in Chapter 3 regarding the support provided by JIs to victims.<sup>140</sup> The JI has no equivalent in England in criminal proceedings, and criminal investigations are undertaken by the police and the CPS, and more particularly now, by the Special Crime and Counter Terrorism Division (SCCTD) since 2005.<sup>141</sup> This has no impact on the present case as the SCCTD did not exist at the time of the episode. However, the CPS was

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<sup>133</sup> Interview with Marie-Odile Bertella-Geffroy, above n117 at 6.

<sup>134</sup> A Thoraval, 'Sang contaminé: pas d'empoisonnement, selon le Parquet.', *Libération*, 6 juin 2000.

<sup>135</sup> Interview with Marie-Odile Bertella-Geffroy, above n117 at 6.

<sup>136</sup> *Ibid* 6.

<sup>137</sup> A Thoraval, 'Sang contaminé: l'empoisonnement en suspens. Pendant cinq jours, l'affaire va être débattue devant la chambre d'accusation de Paris. Enjeu: un procès aux assises', *Libération*, 5 juin 2000.

<sup>138</sup> *Ibid*.

<sup>139</sup> A Thoraval, 'Les paris juridiques de la juge Bertella-Geffroy. Le choix de l'empoisonnement sera très discuté à la chambre d'accusation', *Libération*, 21 mai 1999.

<sup>140</sup> See ch3 pt3.4.1, 71.

<sup>141</sup> The SCCTD did not exist at the time of the episode so it would not have been involved in proceedings arising out of the blood episode; See ch3 pt3.4.1, 71; D Griffiths, A Sanders, 'The road to the dock: Prosecution Decision-Making in Medical Manslaughter Cases, in D Griffiths, A Sanders (eds), *Medicine, Crime and Society* (Cambridge University Press Forthcoming 2013) 119.

created in 1986, so did exist at the relevant time. We have seen in Chapter 3 that the police and the CPS tend to be more reluctant than French JIs to prosecute doctors or health officials.<sup>142</sup> Thus, in England, there was no authority that could have counterbalanced the power of the CPS and the police and which could have asked for the prosecution of doctors or officials, based on the information collected. As explained earlier, an investigation was conducted by the CPS in 2002-3 on the blood episode to prosecute doctors and health officials. Why did the case not go through? Experts claimed that it would be impossible to ‘prove that those in power had sanctioned the blood imports in the 1970s and 1980s knowing that they were contaminated’.<sup>143</sup> In France, experts were involved only in the third set of proceedings but had only a limited role. In all three sets of proceedings, JIs had the right to seize documents from health authorities which was crucial in the understanding of the decision-making process on the blood contamination at the time. JIs analysed in detail the decision-making process and assessed the level of culpability of the accused. On the other hand in England, even though the CPS can requisition documents, investigations conducted by the CPS and the police have a more limited scope because there is not one single person driving investigations as in France and who thus has an overview of the investigations as a whole.<sup>144</sup>

This suggests that JIs and the *commission d’instruction* were in favour of prosecuting officials and doctors in the blood episode in France because they had access to a great deal of evidence which proved that doctors and health officials were culpable. French prosecutors were in favour of using the criminal law whereas in England a CPS prosecution was barely even considered. This may also suggest that the media had a significant role in the episode, and a larger range of offences was accessible to prosecutors and judges. In Chapter 7, I will discuss whether we can learn from the way in which JIs conduct their investigations in healthcare malpractice cases and whether we could achieve effective investigations by using alternatives to the criminal process in England.<sup>145</sup>

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<sup>142</sup> See ch3 pt3.5, 82.

<sup>143</sup> D Black, above n66.

<sup>144</sup> As shown in Ch3 pt3.4.1, 71, although this might be slightly different now since ‘medical manslaughter’ are dealt with by the Special Crime and Counter Terrorist Division (SCCTD).

<sup>145</sup> See ch7 pt7.3.2, 215.

### 5.3.3 Role of the Media and the Public

The blood episode needs to be in part distinguished from other more ‘usual’ cases of healthcare malpractice analysed in Chapters 2 and 3. In France, the blood episode was characterised by great media coverage and public outrage in France, becoming a major scandal. In this section, I show that the media and the public had a great impact on the way criminal law was used in France in the blood episode.

In 1991, journalist Anne-Marie Casteret published in *L'Événement du jeudi* an article that disclosed minutes of the CNTS meeting on 29 May 1985<sup>146</sup> in which there was evidence of negligence of CNTS officials in setting up and implementing HIV-testing and evidence of delays in donor screening and other measures for reducing the contamination.<sup>147</sup> The article disclosed that during the meeting, Garretta announced that ‘all [blood] lots [were] contaminated’.<sup>148</sup>

From this point, the affair became a scandal.<sup>149</sup> The public became well aware that the responses given by health officials had been ineffective in stopping the contamination.<sup>150</sup> Even though criminal complaints had already been lodged in 1988 by victims of the contamination, this article played a crucial role in the prosecution of the four doctors in the first set of proceedings. Bertella-Geffroy affirmed that the MP were about to close the case but after the article was published, they decided to prosecute the four doctors.<sup>151</sup>

Terms used by the media at the time in France seem to illustrate how journalists and perhaps the public saw the responses given by doctors, health officials and ministers to the contamination. They used phrases and terms such as: ‘[...] *par quelle aberration l’une des plus riches démocraties de notre planète a pu enfanter l’affaire dite du sang contaminé*’ (‘[...] through which aberration one of the richest democracies in the world could have given birth to *L’Affaire du sang contaminé*’)<sup>152</sup>, ‘[...] *le spectacle de la déroute commune des plus hautes instances médicales,*

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<sup>146</sup> See Ch4, 114.

<sup>147</sup> D Marchetti, ‘La genèse médiatique du “scandale du sang contaminé”’ in *Ethique, sida et société*. Rapport d’activité du Conseil national du sida (Paris: La Documentation Française Janvier 1993) 25.

<sup>148</sup> Ibid.

<sup>149</sup> Interview with A (Cambridge, United Kingdom, 3 February 2011) 11.

<sup>150</sup> AM Casteret, ‘La tragédie des hémophiles’, *L’Express*, 4 décembre 1987 ; P Froguel, C Smadja, ‘Les dessous de l’affaire du sang contaminé’, *Le Monde Diplomatique*, février 1999.

<sup>151</sup> Interview with Marie-Odile Bertella-Geffroy, above n117 at 5.

<sup>152</sup> L Greilsamer, above n6 at 7.

*administratives et politiques de notre pays*’ ([...] the sight of the collective ruin of the highest medical, administrative and political authorities of our country’)<sup>153</sup>, *‘indignité médicale’* (‘medical indignity’)<sup>154</sup>, and *‘grand dérapage incontrôlé’* (‘big uncontrolled slip’).<sup>155</sup>

The media may have represented the view the French public had on the contaminated blood episode at the time of the criminal proceedings.<sup>156</sup> The literature on the topic agrees to say that the public, by a great majority, wanted to see doctors, health officials and ministers appear before a criminal court.<sup>157</sup> In their opinion, the people allegedly responsible for the contamination needed to ‘pay’, especially members of the executive.<sup>158</sup> Members of the public who had attended the trial in the first set of proceedings were aggressive towards the accused and some of the witnesses, especially towards members of the executive (Prime Minister Laurent Fabius and Minister of Social Affairs Georgina Dufoix who were witnesses in the first set of proceedings): *‘le prétoire avait des allures d’arène et la rumeur hostile de la rue s’y engouffrait par ses fenêtres grandes ouvertes’* (The courtroom looked like a bullring and the hostile atmosphere of the street was getting into it through its wide open windows).<sup>159</sup>

A journalist claimed that ‘the contaminated blood affair, exploited by opposition parties and publicised in harrowing television documentaries, [had] become far and away the biggest scandal to have dogged the deeply unpopular Socialist Government’.<sup>160</sup> This was confirmed by Marchetti who stated that the media helped in the ‘politicisation’ of the episode.<sup>161</sup> An example of the outrage of the victims and the public in the scandal is Garetta’s car being blown up in 1990.<sup>162</sup>

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<sup>153</sup> Ibid.

<sup>154</sup> Ibid.

<sup>155</sup> Ibid.

<sup>156</sup> Assemblée Nationale, Rapport de la commission d’enquête sur l’état des connaissances scientifiques et les actions menées à l’égard de la transmission du sida (Union générale d’édition 1993) 180 ; D Marchetti above n146.

<sup>157</sup> O Beaud, above n111 at 1; L Greilsamer, above n6 at 198.

<sup>158</sup> O Beaud, above n111 at 2.

<sup>159</sup> L Greilsamer, above n6 at 159, 161, 163, 165.

<sup>160</sup> N Powell, ‘Jailed doctors seen as scapegoats in French Aids trial’ *The Herald* (Paris, 24 October 1992).

<sup>161</sup> Interview with Dominique Marchetti, above n79 at 5.

<sup>162</sup> N Powell, above n159.

The trial of ministers had two purposes in the eyes of the public: to understand what had really happened in the decision-making process leading to the contamination, and to see the ‘real responsible people’ pay for what they had done, which suggested public vengeance.<sup>163</sup> Beaud and Hermitte affirmed that the public had a decisive role in the use of criminal proceedings against ministers.<sup>164</sup>

In England, the blood episode also became a scandal but it seems that in France, the episode was marked by greater outrage from the media, the public and the victims against ministers and health officials. In England, a search of newspapers between 1984 and 2010 showed that the episode was also viewed as a scandal in some articles.<sup>165</sup> From 1985, articles reported that the NHS had been importing blood products at risk of HIV-contamination.<sup>166</sup> One article reported that Dr John Cash (then medical director of the blood transfusion service in Scotland) had made substantive criticism about the blood transfusion service in England and Wales.<sup>167</sup> He criticised the blood transfusion service’s ‘bad management’.<sup>168</sup> He denounced a ‘wasteful and dangerous management system’, and ‘inappropriate supervision of the use of blood and blood products by the hospital blood banks’.<sup>169</sup> He called the National Blood Transfusion Service ‘a fragmented and disorganised shambles’.<sup>170</sup>

The English media also acknowledged that there had been delays in implementing measures against HIV-contamination of the blood supply, particularly heat-treatment (‘two-year delay’).<sup>171</sup> A journalist denounced the fact that health officials had given priority to profit rather than blood safety: ‘there is bound to be suspicion that the blood transfusion service is being run by accountants and penpushers rather than experienced medical professionals for whom the welfare of patients and donors has

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<sup>163</sup> O Beaud, above n111 at 2.

<sup>164</sup> O Beaud, above n111 at 48.

<sup>165</sup> D Black above n66; Unknown author, ‘Blood scandal that cannot go unpunished’ *Mail on Sunday* (London, 9 July 1995); C Macrae, ‘Scandal of the forgotten NHS Aids sufferers’, *The Observer*, 21 April 1991.

<sup>166</sup> A Veitch, ‘No check on blood despite Aids fear/Import of plasma products from the US’, *The Guardian* (London, 25 March 1985); A Veitch, ‘The spread of Aids blamed on blood trade’, *The Guardian* (London, 22 March 1985).

<sup>167</sup> See Ch4, 103.

<sup>168</sup> Unknown author, ‘Blood transfusion service ‘dangerous shambles’’, *The Times* (London, 11 September 1987).

<sup>169</sup> Ibid.

<sup>170</sup> Ibid.

<sup>171</sup> A Veitch, ‘Aids blood victims claim 30 million pounds from NHS’, *The Guardian*, 14 October 1987.

always come first'.<sup>172</sup> He argued that the Secretary of State for Health 'must order an immediate inquiry into this fiasco and be prepared to sack those who are to blame. Nothing less will suffice'.<sup>173</sup>

In England, the episode was subject to media coverage and criticism, but it is noticeable that the language used in French articles was much more inflammatory than in English articles. In England, not one article disclosed minutes of meetings of health authorities or named particular doctors or health officials who had been negligent. The role of the media, criminal prosecutions and the gradual disclosure of documents however demonstrates the level of outrage in France at the time of the episode and seems to go a long way in explaining the use of criminal proceedings in France, also resulting from the fact that in France the affair was more 'politicised'.<sup>174</sup> The trial of Ministers was a direct consequence of the 'politicisation' of the episode.

#### 5.3.4 Possibility to Prosecute Ministers in France

A crucial feature of the HIV-contaminated blood scandal in France which seems to differentiate it from other healthcare malpractice cases and episodes is the use of criminal proceedings against ministers. I argue in this section that the possibility to prosecute ministers in France had a great impact on the way the criminal process was used in the HIV-contaminated blood episode in France. It has been said that the use of the criminal process against ministers in France in the blood episode was a consequence of the 'politicisation' of the episode.<sup>175</sup>

Before 1993 in France, only the Parliament could ask for the prosecution of ministers in the *Haute Cour de Justice*<sup>176</sup> (HCJ) for actions committed as part of their duties.<sup>177</sup> On 7 October 1992, the *Assemblée Nationale* proposed to prosecute the three ministers for being accessory to *empoisonnement*.<sup>178</sup> The proposition was rejected. The *Sénat* then proposed to prosecute the three ministers for *homicide involontaire*,

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<sup>172</sup>Unknown author above n164.

<sup>173</sup> Ibid.

<sup>174</sup> Interview with Dominique Marchetti, above n79 at 5.

<sup>175</sup> Ibid.

<sup>176</sup> The *Haute Cour de Justice* was the criminal court for members of the Government in France before 1993.

<sup>177</sup> O Beaud, above n111 at 48; Article 68 al 2 Constitution du 4 octobre 1958 (abrogé).

<sup>178</sup> O Beaud, above n111 at 49; MA Hermitte, above n8 at 447.

*blessures involontaires, non-assistance à personne en danger* and *tromperie*.<sup>179</sup> After a series of political discussions and negotiations between the Right and the Left, the Parliament voted for the prosecution of the three ministers for *non-assistance à personne en danger*.<sup>180</sup> Investigations started in the *commission d'instruction* of the HCJ. On 5 February 1993, the commission stopped the investigations by claiming that the *Action Publique*<sup>181</sup> fell outside the relevant limitation period for such offences (*prescription*)<sup>182</sup> 5 years before.<sup>183</sup> The commission suggested therefore using the offence of *homicide involontaire* which permitted to interrupt the *prescription* every time a victim died.<sup>184</sup> But the socialist Members of the Parliament wanted to prosecute the ministers for *non-assistance à personne en danger*.<sup>185</sup> The Parliament did not prosecute and the HCJ closed the file on 21 April 1993.<sup>186</sup>

On 27 July 1993, a statute created the CJR which replaced the HCJ.<sup>187</sup> The President of the Republic took the initiative to revise the Constitution in order to establish a court to try the three ministers on criminal grounds.<sup>188</sup> At the time, ministers were facing very hostile accusations from the public.<sup>189</sup> Prime Minister Laurent Fabius himself asked to be tried.<sup>190</sup> The President of the Republic claimed that it was in the ministers' interest to be tried in order to prove that they were innocent.<sup>191</sup> This reform was part of a bigger project that aimed to make citizens more involved in legal matters and reform legal procedures (for instance, one of the aims of the reform was to improve judges' independence from the executive) but it was a direct consequence of the contaminated blood scandal.<sup>192</sup> The HCJ's reform had two main purposes: to allow individual victims to lodge criminal complaints against a minister who would have committed a *délit* or a *crime* as part of his duties, and to institute a

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<sup>179</sup> MA Hermitte, above n8 at 448.

<sup>180</sup> O Beaud, above n111 at 50; MA Hermitte, above n8 at 449.

<sup>181</sup> See Ch3, 65.

<sup>182</sup> *Prescription de l'Action Publique* is the time delay within which a criminal offence can be prosecuted from its commission. Each category of offence has a different *prescription*. The *prescription* for *délits* is three years.

<sup>183</sup> O Beaud, above n111 at 51; MA Hermitte, above n8 at 450.

<sup>184</sup> O Beaud, above n111 at 51.

<sup>185</sup> MA Hermitte, above n8 at 451.

<sup>186</sup> O Beaud, above n111 at 51.

<sup>187</sup> Loi organique n°93-1252 du 23 novembre 1993 sur la Cour de justice de la République.

<sup>188</sup> O Beaud, above n111 at 51-52.

<sup>189</sup> L Joffrin, Editorial 'Le devoir de juger', *Libération*, 8 février 1999.

<sup>190</sup> Ibid.

<sup>191</sup> MA Hermitte, above n8 at 435.

<sup>192</sup> Ibid 436.



court composed of professional judges (*magistrats professionnels*) and senior civil servants, independent from the executive.<sup>193</sup> The complaint commission (*commission des requêtes*) in the new CJR is composed of professional judges.<sup>194</sup> It has the duty to sort out individual criminal complaints and decide whether to send the case to the general prosecutor (*procureur général*) or close the case.<sup>195</sup> Victims can now lodge criminal complaints against ministers but cannot be *parties civiles* in criminal proceedings involving ministers.<sup>196</sup> However, victims can ask for civil compensation in other courts.<sup>197</sup> One important point needs to be emphasised: any person can now bring accusation against a minister for a decision he made as part of his duties if it amounted to a criminal offence in France.<sup>198</sup> Thus, as well as being politically accountable before the Parliament, ministers in France are now criminally liable for actions committed as part of their functions.<sup>199</sup>

In England, there is no formal immunity for ministers from prosecution for criminal offences. Thus in theory, the CPS could have prosecuted ministers for criminal offences analysed earlier, GNM and causing GBH. However, since a prosecution against health officials failed in 2002/3, it is difficult to imagine that a prosecution against ministers or the Prime Minister would have been successful. Also, ministers have never been prosecuted in England for failures made as part of their ministerial activities. The only small possibility would have been for blood victims to bring a private prosecution against ministers. However, private prosecutions are expensive and it can be difficult for victims to gather sufficient evidence in order to meet the standards of proof required in criminal proceedings, whereas in France, all the investigating work was done by JIs. Moreover, the Attorney General would have discretion on whether or not to let the case go through. In France, even though victims could not be *parties civiles* in proceedings involving ministers, they had the right to lodge criminal complaints, which were supported by *juges d'instruction*.

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<sup>193</sup> Ibid.

<sup>194</sup> Article 12 Loi organique n°93-1252, above n186; MA Hermitte, above n8 at 464.

<sup>195</sup> Article 68-2 al 3 Loi organique n°93-1252, above n186.

<sup>196</sup> Article 13 Loi organique n°93-1252, above n186.

<sup>197</sup> Ibid.

<sup>198</sup> Article 68-2 al 2 Constitution du 4 octobre 1958.

<sup>199</sup> Article 68-1 Constitution du 4 octobre 1958.

Thus, it seems that ‘the only way ministers could have been held to account was to Parliament’.<sup>200</sup>

In England, there is no court specifically designed to judge ministers on criminal grounds as is the case in France and individuals cannot lodge criminal complaints against ministers. Thus, the possibility to try ministers on criminal grounds for actions committed as part of their duty in France was a crucial factor which explained why the criminal process was more readily used in France in the episode. This may also confirm the idea that the French may be more eager to use the criminal process against members of the central power following a crisis or scandal.<sup>201</sup> Indeed, other ministers were tried in the CJR after the blood scandal.<sup>202</sup> Some of them were convicted and some of them were acquitted. However, the charges were all of intentional offences. For instance, in 2010, Charles Pasqua former interior minister in the 1990s, was convicted to one year suspended for concealment of public funds (*recel d’abus de bien sociaux*).<sup>203</sup>

## 5.4 Conclusion

This chapter compared the role of substantive criminal law and criminal procedure in the HIV-contaminated blood episode in France and England.

Grievances of contaminated victims in France and England were similar and based on the same allegations that blood authorities and blood officials had failed to take measures against the contamination soon enough. The chapter has shown that substantive and procedural features of French criminal law as well as social factors and the media had a great impact on criminal proceedings arising out of the episode.

In France, there was a broader range of intentional and negligence offences which could have applied to healthcare malpractice cases. In England, criminal law did not offer the same range of offences. However, the use of the criminal law could have

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<sup>200</sup> AM Farrell, above n1 at 140.

<sup>201</sup> See Ch1, 27.

<sup>202</sup> Unknown author, ‘Le sixième ministre jugé par la Cour de Justice de la République’, *Libération*, 18 avril 2010.

<sup>203</sup> Unknown author, ‘French ex-police boss and Chirac ally Pasqua convicted’, *BBC News*, 30 April 2010; Unknown author, ‘Former minister Pasqua gets suspended sentence for corruption’, *France 24*, 30 April 2010.

been possible in England using section 20 of the OAPA 1861, GNM and/or health and safety offences.

In France, victims had the possibility to lodge criminal complaints with *constitutions de partie civile* against doctors and health officials and could lodge criminal complaints against ministers. The first and third sets of proceedings in France were thus a direct consequence of the involvement of *parties civiles*, who had proposed charges against the accused. In England, victims did not have the possibility to be *parties civiles*. They could only have brought a private prosecution but the CPS<sup>204</sup> would have had the last word in terms of deciding whether or not to prosecute. But the success of such a prosecution would seem unlikely since police investigations on the blood episode in 2002/3 did not lead to prosecutions. In France, JIs and prosecutors usually supported the victims' claims but judges were more reluctant to convict in the second and third sets of proceedings. The disclosure of documents and the escalation of a 'scandal' also encouraged JIs and prosecutors to send doctors, health officials and ministers to criminal court. The possibility to prosecute ministers in a criminal court in France was also a determinant factor in the use of the criminal process in the blood episode. In the next chapter, I will discuss whether the use of the criminal law in the blood episode was efficient and appropriate to respond to victims' demands and ensure healthcare safety, compared to other legal responses which were used in England (independent inquiry, ex gratia payments and civil litigation) and whether the English system could learn from features of the French system as used in the blood episode.

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<sup>204</sup> The CPS came into existence in 1986 so proceedings could have been brought arising out of the blood episode in England from 1986. See <<http://www.cps.gov.uk/about/history.html>>.

## **6. Was the Criminal Process an Effective Response to the HIV-Contaminated Blood Episode in France and England?**

### **6.1 Introduction**

In the previous chapter, I have found that features of substantive criminal law and criminal procedure had a significant impact on the use of the criminal process in the blood episode in France. The wider range of criminal offences in French criminal law, the role of *parties civiles* and the support of *juges d'instruction* (JIs) were major factors explaining the use of the criminal process in the blood episode in addition to social and political factors.

In both countries, victims sought an understanding of the causes of the contamination and possible deficiencies of the system as well as 'justice', deterrence and retribution, which are among the aims of the criminal law in both countries.<sup>1</sup> In France and England, victims asked for the 'truth' about what had happened to make sure that similar healthcare disasters would not happen in the future. In both countries, victims and families claimed that this was the reason why they wanted to use the criminal process.<sup>2</sup> However, whereas victims of the blood episode had access to the criminal process in France, victims of the blood episode in England had to rely on civil proceedings which failed in offering the victims retribution, transparency, accountability and closure, and received ex gratia payments which were said to be too low. The Archer Inquiry, an independent inquiry conducted over 20 years after the contamination, seemed to have been the only useful response to English victims' demands for transparency and closure.

The scope and level of payments received as a result of civil proceedings begun in 1989 in England fell far below the level that the infected individuals and their

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<sup>1</sup> Unknown author, 'Victory for the victims', *The Journal*, 30 August 2003.

<sup>2</sup> Unknown author, 'Criminal probe into bad blood considered', *The Journal*, 14 August 2002; J Duffy, 'Health department branded 'arrogant' over blood inquiry; NHS: Scandal; Haemophiliacs' fury after failure to give evidence', *The Sunday Herald*, 17 June 2007; E Favereau, 'Le procès du sang contaminé. « C'est bidon, mais c'était couru d'avance ». Les associations de victimes, déçues, jugent cependant que le procès n'a pas été inutile', *Libération*, 10 mars 1999.

families considered acceptable.<sup>3</sup> Just as did French victims, English victims and victims' groups alleged that English health authorities and the Department of Health (DH) had not responded to the contamination in an appropriate way and asked not only for explanation and apologies from the DH, but also for greater ex gratia payments or compensation, in accordance with what was given to HIV victims in Ireland.<sup>4</sup> The anger of patients and families remains strong to this day in England.<sup>5</sup> The extra-legal response in England may have taken a little heat from the scandal but, as will be shown in this chapter, did not meet the victims' demands for compensation, transparency or accountability. The Archer Inquiry<sup>6</sup> was conducted in 2009 and made recommendations to the DH, which were not all followed.<sup>7</sup> The DH always refused to apologise to victims and hold a public inquiry.<sup>8</sup> Victims have still not been given what they sought.<sup>9</sup> In France, victims were also dissatisfied with the outcome of the criminal proceedings, which suggests that none of the responses were effective in meeting victims' demands, and that the criminal process is not, by itself at least, a wholly appropriate response to systemic failure in health services of the kind illustrated by the contaminated blood episodes.

I now begin to address the question of when and where the criminal law rightly sits in the business of redressing/preventing massive failures in a healthcare service as illustrated by the blood episodes. This chapter first aims to identify whether criminal offences analysed in Chapter 5 were or would have been appropriate to use in the blood episode and if they gave, or would have given, an efficient response to the

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<sup>3</sup> Mr Justice Horace Krever, Commission of Inquiry on the Blood System in Canada, Final Report Vol 3, 1997, 939-942; S Threakall, 'Government Announces another Inadequate Support Scheme for Contaminated Blood Sufferers', *Tainted blood* (London, 10 January 2011).

<sup>4</sup> S Watts, 'Government payments for haemophiliacs unlikely to satisfy campaigners', *BBC News*, 10 January 2011.

<sup>5</sup> G Colthart, 'HIV and Hepatitis C infection from contaminated blood and blood products', House of Commons, 13 January 2011; HC Deb, 14 October 2010, vol 516, cols 521-571; Department of Health, Government response to Lord Archer's Independent report on NHS supplied contaminated blood and blood products, 20 May 2009; Rt Hon Lord Archer of Sandwell QC, Independent Public Inquiry Report on NHS Supplied Contaminated Blood and Blood Products, 23 February 2009, 101-104.

<sup>6</sup> The Archer Inquiry was an independent public inquiry conducted in 2009 by the Rt Hon Lord Archer of Sandwell QC to investigate on the HIV and Hepatitis C contamination of NHS blood supply occurred in the 1980s. The inquiry is examined later in the chapter.

<sup>7</sup> Rt Hon Lord Archer of Sandwell QC, above n5 at 107-110.

<sup>8</sup> Unknown author, 'Contaminated blood cases 'tragic'', *BBC News*, 3 December 2009; Unknown author, 'Health department branded 'arrogant' over blood inquiry; NHS: SCANDAL; Haemophiliacs' fury after failure to give evidence', *The Sunday Herald*, 17 June 2007.

<sup>9</sup> See <<http://www.taintedblood.info/index.php>>, a countdown shows that three years after the Archer Inquiry, the recommendations have still not been addressed 'seriously'; G Colthart, above n5; HC Deb, above n5; Department of Health, above n5; Rt Hon Lord Archer of Sandwell QC, above n5.

episode in both countries. I will show that courts had difficulty finding an offence which was appropriate to apply to actions committed by doctors, health officials and ministers in the blood episode and which would have responded to the victims' demands for justice and retribution and ensured deterrence and prevention of similar healthcare malpractice episodes. It will be shown that even though the range of criminal offences in France 'assisted' the victims in getting what they had asked for in terms of justice and retribution, judges considered that intentional offences required a high level of moral culpability, whereas negligence offences did not offer sufficient retribution to victims.

The chapter seeks to determine which of the approaches used to address the episode in France and England (if any) was the most appropriate and the most useful regarding blood safety and victims' demands for compensation, transparency and accountability. I focus more particularly on the question of whether the criminal process is designed or apt to resolve healthcare malpractice episodes such as the blood episode. I consider whether the French model of criminal justice offered a better platform to ensure that the aims and functions of the criminal law were effectively fulfilled. The analysis will help to find out whether lessons can be learnt from looking at the outcome of using the criminal process to respond to healthcare disasters.

I suggest that, even though victims' demands for justice and retribution when something terrible has happened are comprehensible, the criminal process should only be used to criminalise intentional conduct or conduct which shows subjective fault, which I began to argue in Chapter 4, should be at the level of recklessness and should not be used only to respond to victims' need for justice when there was no significant moral culpability on the part of the accused. In this chapter, it will be demonstrated that the criminal process was of limited use in ensuring healthcare safety and responding to victims' demands. However, the French inquisitorial process proved to be useful in investigating the decision-making process in the blood episode, identifying individuals at fault and pointing out deficiencies in the decision-making process.

The chapter looks at the usefulness of the criminal process in dealing with victims' needs and health safety in the blood episode. The literature on the topic generally

analyses the issue of whether criminal offences were legally appropriate to apply in the blood episode in France but there is a gap in the literature on the question of whether the criminal process effectively provided restoration and retribution to victims, as well as transparency and prevention in blood safety, and whether the criminal process should be used to regulate healthcare malpractice episodes more generally.<sup>10</sup> I try to address this gap in this chapter using a comparative analysis of legal responses used in England as a response to the episode with the use of the criminal process in France. The comparison aims at determining whether the criminal law should be used as a regulatory tool—not only to penalise morally wrongful conduct—in the context of healthcare malpractice with offences similar to *délits* which involve a lesser stigma than gross negligence manslaughter (GNM) in England.

## **6.2 Usefulness and Effectiveness of Substantive Criminal Law as a Response to the HIV-Contaminated Blood Episode**

In France, as we have seen, few of the criminal prosecutions resulted in convictions. Out of over 30 people prosecuted, only five were convicted. Two *Centre National de Transfusion Sanguine* (CNTS) directors were given jail sentences, two health officials were given suspended sentences and a minister was given an absolute discharge. The outcome of the proceedings did not generally satisfy the victims, the public or commentators of the episode. Victims claimed that the need for retribution had not been met as sentences were too low and only five individuals were convicted.<sup>11</sup> Journalists and academics claimed that the accused had been used as scapegoats as only some people were convicted, whereas the blood supply organisation involved many people, whom, they claimed, were also responsible.<sup>12</sup>

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<sup>10</sup> MA Hermitte, *Le sang et le droit. Essai sur la transfusion sanguine* (Seuil 1996) ; O Beaud, *Le sang contaminé, Essai critique sur la responsabilité des gouvernants* (Presses Universitaires de France 1999) ; J Pradel (Dir.), *Sang et droit pénal. A propos du sang contaminé*, Travaux de l'Institut de sciences criminelles de Poitiers (Edition Cujas 1995).

<sup>11</sup> A Thoraval, 'Une première dans l'histoire de la Ve République. Sang contaminé : le tribunal pour trois ministres. Laurent Fabius, Georgina Dufoix et Edmond Hervé seront jugés pour « homicides involontaires ». Ils étaient ministres au moment où des centaines d'hémophiles et de transfusés ont été contaminés par le VIH', *Libération*, 18 juillet 1998 ; L Greilsamer, *Le procès du sang contaminé* (Le Monde Editions 1992) 97.

<sup>12</sup> L Greilsamer, above n11 at 184.

This section aims to assess how far substantive criminal law was a just and appropriate means to address failure in the healthcare service in the HIV-contaminated blood episode. I demonstrate that the use of intentional offences responded to the victims' need for retribution but their outcome was not satisfactory for the victims as only few of the cases succeeded. I suggest that negligence offences were more appropriate to apply to the failures that ensued from contamination of the blood supply, but only when there was evidence of recklessness on the part of doctors, health officials and ministers.<sup>13</sup>

My account in this section also illustrates the case made in earlier chapters for the importance of JIs and *parties civiles* in pressing for charges.

### 6.2.1 Intentional Offences

In France and England, intentional offences are designed to criminalise acts which aim to harm others as acts with guilty intent or fraud are most easily seen as the business of the criminal law and are different from inadvertent failures.<sup>14</sup> In Chapter 4, I argued that some of the failures committed by blood officials and doctors in the HIV-contaminated blood episode did amount to recklessness and were serious enough to be punished by criminal law, although they did not demonstrate any type of intentional conduct. Yet, some of these failures in France were the subject of prosecutions for intentional offences.

The resort to intentional offences might have been seen as more likely to satisfy the victims' need for retribution and justice but save for *tromperie*, which was not considered adequate, all the other prosecutions failed.

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<sup>13</sup> I argue in Ch7, 7.2, 201, that the criminal law should only have a role in healthcare malpractice when there is a certain level of disregard for patients' safety at the level of recklessness.

<sup>14</sup> Assemblée Nationale, Rapport n° 2266 fait au nom de la commission des lois constitutionnelles, de la législation et de l'administration générale de la République sur la proposition de loi, adoptée par le Sénat, tendant à préciser la définition des délits non intentionnels, par M René Dosièrre, 22 mars 2000, 4; A Ashworth, *Principles of Criminal Law* (6<sup>th</sup> edn, Oxford University Press 2009) 1.



## ***Tromperie* and Fraud Offences**

As explained in the previous chapter, the only two jail sentences in the blood episode in France were based on the use of *tromperie* against Drs Garetta and Allain. So it could be said that perhaps the use of this offence was a constructive and appropriate use of the criminal process, but neither the victims nor doctors or commentators were satisfied with its outcome or found it appropriate (see below). Victims claimed that *tromperie* was not sufficient to represent the scale of the tragedy and doctors and some commentators argued that proceedings for *tromperie* were unjust and the accused had been used as scapegoats (see below).

*Tromperie* is not a usual type of deception offence. As explained in the previous chapter, it is an offence designed to repress fraud in the food industry, which is very different than most instances of healthcare. Victims saw *tromperie* as a low level offence more akin to trading standards violations. On the other hand, doctors and others saw the use of *tromperie* as unjust. *Tromperie* was an offence against misrepresentations in quality of food which was seen by victims as different from error and cover ups in healthcare. In theory, *tromperie* could have been appropriate to apply to the blood case but the nature of the offence diminished the tragic aspect of the situation.

The main motivation of some of the victims in using *tromperie* in the first set of proceedings arising out of the blood episode in France was to get faster and easier access to criminal proceedings and compensation. It was argued that a prosecution for *empoisonnement* or *homicide involontaire* would have been more difficult. *Empoisonnement* was a *crime* and would have been dealt with in the *Cour d'Assises*<sup>15</sup> and the *Ministère Public* (MP) would have been more reluctant to prosecute for a *crime*.<sup>16</sup> *Tromperie* was a *délit* and dealt with in the *Tribunal correctionnel* so the chances that the MP would prosecute a *délit* were greater.<sup>17</sup> *Tromperie* was used to facilitate and accelerate the proceedings so that the trial

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<sup>15</sup> In France, *Cour d'Assises* is the court in charge of judging *crimes*; B Bouloc, *Procédure Pénale* (22<sup>e</sup> edn, Dalloz, 2010) 480.

<sup>16</sup> Unknown author, 'Le procès du sang contaminé. Le vrai procès reste à venir', *Libération*, 10 mars 1999; O Beaud, above n10 at 42.

<sup>17</sup> See ch2, 42.

would take place before victims died.<sup>18</sup> It was chosen to emphasise the fact that Garetta and Allain had deceived Haemophilia patients by not informing them of the risk of contamination through factor concentrates (FCs) although they were aware of the risk from 1983.<sup>19</sup> *Tromperie* was initially proposed by the victims (their lawyers) because it had advantages for victims over *homicide involontaire*. It could apply to any victim, whereas *homicide involontaire* could apply only to dead victims, and the causal link was easier to prove.<sup>20</sup> In the case of *homicide involontaire*, a causal link had to be proven between each victim's death and each accused's action. In the case of *tromperie*, only the fact that the accused had deceived the victims had to be proven. In theory, *tromperie* provided greater retribution than *homicide involontaire* as it was punished by maximum 4 years imprisonment whereas *homicide involontaire* was only punished by 2 years imprisonment at the time of the first set of proceedings.<sup>21</sup> No requirement of a *faute caractérisée* existed at the time.

Nonetheless, some victims, academics and journalists expressed criticism about the use of charges of *tromperie*. Victims and some academics argued that *tromperie* was a *délit* designed to criminalise foodstuffs falsification and fraud.<sup>22</sup> The use of *tromperie* assimilated blood to a mere commercial good. It was referred to as '*délit d'épicier*' (grocer offence).<sup>23</sup> Thus, it was argued that *tromperie* did not represent the gravity of the offending conduct and reduced the contamination to a simple 'grocer/consumer' dispute.<sup>24</sup> It was claimed that *tromperie* did not emphasise the 'homicide' aspect of the situation.<sup>25</sup> A victim's advocate alleged that 'the *Loi de 1905* [was] not appropriate. Blood [could] not be assimilated to yogurt, mustard or soda'.<sup>26</sup>

Some also argued that blood was not a product which could be counted and thus was not included in the definition of *Loi du 1er Août 1905* which required that the

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<sup>18</sup> A Thoraval, 'Une instruction à rebondissements. Lenteurs et chausse-trapes. Les magistrats instructeurs ont fait face à un Parquet hostile', *Libération*, 8 février 1999.

<sup>19</sup> See Ch4 pt4.5.3, 117; L Greilsamer, above n11 at 60.

<sup>20</sup> O Beaud, above n10 at 42.

<sup>21</sup> Art 319 Ancien Code Pénal (ACP); MA Hermitte, above n10 at 394.

<sup>22</sup> MA Hermitte, above n10 at 374.

<sup>23</sup> Ibid.

<sup>24</sup> Ibid; JP Delmas Saint-Hilaire, 'Un crime d'empoisonnement: la double tromperie de l'Affaire du sang contaminé cessera-t-elle enfin?' in J Pradel (Dir.), *Sang et droit pénal. A propos du sang contaminé*, Travaux de l'Institut de sciences criminelles de Poitiers (Edition Cujas 1995) 45.

<sup>25</sup> MA Hermitte, above n10 at 374.

<sup>26</sup> L Greilsamer, above n11 at 196.

products could be counted and measured and could be object of a transaction. Before treatment, blood did not have a financial value; but after being treated and fractionated in the CNTS, blood and blood products had acquired a financial value. The MP argued that FCs were industrial products and therefore were included in the *loi*, after manufacturing processes.<sup>27</sup> The MP explained that even if blood had no commercial value, FCs, however, were sales items with a price fixed by ministerial order and were thus included in the definition of *tromperie*.<sup>28</sup>

There were also debates on the question of whether *tromperie* was meant to protect humans only and, as will be shown later, this had consequences regarding the use of *non-assistance à personne en danger* against Roux and Netter.<sup>29</sup> In the criminal proceedings, judges only mentioned ‘a product dangerous for human health’ but the *Loi de 1905* referred to ‘[...] product dangerous for human or animal health’.<sup>30</sup> Therefore, it was difficult to determine whether this offence was designed to protect the bodily integrity of a person since it would have assimilated humans to animals. If the offence was meant to protect human health, it would be assumed that a distinction would have been made between persons and animals in the *loi*.<sup>31</sup> Thus the use of *tromperie* did not acknowledge the status of victims of a contamination. Some argued that the fact that the court had used the aggravating circumstance of being ‘dangerous for human health or animal health’ made the offence appropriate to apply in the context of healthcare. However, I support the view of Delmas Saint-Hilaire who argued that the aggravating circumstance was not specific to human health and it was thus offensive to victims as it did not acknowledge their status of ‘human’ persons and assimilated them to animals.<sup>32</sup>

It was also argued by some academics that *tromperie* was an intentional offence. Hence, *tromperie* had in theory nothing to do in the context of failure. Its *mens rea* was constituted by the intention to deceive the victims.<sup>33</sup> It was argued that even though they had failed to inform blood patients about the contamination of blood products, there was no evidence that Drs Garetta and Allain did have the requisite

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<sup>27</sup> Ibid 60.

<sup>28</sup> Ibid.

<sup>29</sup> JP Delmas Saint-Hilaire, above n24 at 43; See pt6.2.2.

<sup>30</sup> Ibid 39.

<sup>31</sup> Ibid 43.

<sup>32</sup> Ibid.

<sup>33</sup> MA Hermitte, above n10 at 379.

intention to deceive them. Thus, it was said that *tromperie* should not have been used in the proceedings.

I argue that even though FCs were commercial products, they were still health products and were meant to keep patients alive. In terms of retribution, victims needed to know that the justice system had acknowledged their status of victims of healthcare malpractice. The aim of food manufacturers is profit whereas the aim of health providers should be patients' wellbeing. The CNTS's monopoly on plasma fractionation and drying for 40% of French territory as well as the fact that patients in Paris and the West were supplied by the CNTS significantly reduced their choice of suppliers of blood products. These products were indispensable to keep them alive and patients were dependent on the CNTS. Also, there was a sort of paternalistic relationship between blood patients and CNTS doctors.<sup>34</sup> Thus, blood patients were not simple consumers, and this had to be acknowledged in the choice of offence. Thus, I suggest that *tromperie* should not have been used in the episode.

In England, patients were also deprived of information as shown in Chapter 4. The closest English equivalents of *tromperie* were found at the time in the Theft Act 1968 and the Theft Act 1978 and later in the Fraud Act 2006, which were much more straightforward fraud offences than *tromperie*.<sup>35</sup> I have shown in Chapter 5 that fraud offences contained in these Acts required that the fraud had been committed in order to obtain pecuniary advantage.<sup>36</sup> These offences did not contain an aggravating circumstance for products dangerous for health as *tromperie*.

The closest equivalent of *tromperie* was found in the Consumer Protection Act 1987 (CPA 1987) but could not be used in the episode.<sup>37</sup> As the offences aimed to protect 'consumers' the arguments made about *tromperie* could be made here. Offences under the CPA 1987 were not appropriate as blood patients were different from consumers as explained earlier. However, we should note that the CPA 1987 did allow victims to lodge civil claims with regards to Hepatitis C, so offences under the

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<sup>34</sup> AM Farrell, 'Contaminated Blood, A Comparative Study of Policy-Making Arising out of HIV Contamination of the Blood Supply in France, the United Kingdom and Ireland' (Ph.D. thesis, University of Manchester 2004) 75.

<sup>35</sup> See ch5 pt5.2, 125.

<sup>36</sup> Ibid.

<sup>37</sup> Ibid.

CPA 1987 may have permitted victims to obtain some sort of retribution but only if the Secretary of State had made the necessary regulations.<sup>38</sup>

*Tromperie* seemed effective in getting compensation<sup>39</sup> (although other remedies might have sufficed) and both accountability and punishment. Yet, the use of *tromperie* in the first set of proceedings did not satisfy any of the interested parties. Garetta and Allain, as well as journalists and academics, claimed that they both had been used as scapegoats in the first set of proceedings, which suggests that the criminal process is not suitable to criminalise this type of systemic failure because it only permitted to hold to account a limited number of individuals and could not apply at the corporate level.<sup>40</sup> Moreover, the use of *tromperie* did not respond to the victims' desire for retribution as it did not acknowledge their status of victims of a contamination and was not sufficient to represent the level of harm caused.<sup>41</sup> Numerous victims argued that charges of *empoisonnement* were needed to convict the accused of a *crime*, not merely a *délit* and this resulted in the prosecution of health officials and doctors for *empoisonnement* in the third set of proceedings in France.<sup>42</sup>

### ***Empoisonnement, Administration de Substances Nuisibles and Maliciously Administering Noxious Substances***

On both sides of the Channel, victims and their families argued that in effect, the health service and its officials had 'poisoned' or 'murdered' victims of the contamination.<sup>43</sup> By deliberately concealing information and allowing the continued use of contaminated blood and FCs, the health services were, it was argued, guilty of poisoning, an offence that does amount to a *crime* in France and is a serious criminal

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<sup>38</sup> *A and others v National Blood Authority and another* [2001] 3 All ER 289; Consumer Protection Act 1987 (CPA 1987) Part II s 11 (1). See ch5 pt5.2, 121.

<sup>39</sup> *Parties civiles* received compensation at the end of the first set of proceedings in France. See pt6.3.6 below.

<sup>40</sup> L Greilsamer, above n11 at 184, 192, 210; MA Hermitte, above n10 at 360.

<sup>41</sup> L Greilsamer, above n11 at 182.

<sup>42</sup> *Ibid.*

<sup>43</sup> C Dyer, 'Murdered' Aids victim's fight goes on: Clare Dyer considers the painful death of a haemophiliac infected by imported blood', *The Guardian* (London, 3 August 1990); L Greilsamer, above n11 at 18.

offence in England punished by maximum 10 years in prison.<sup>44</sup> As shown in Chapter 5<sup>45</sup>, the escalation of a scandal, the greater scope of the *judiciarisation*<sup>46</sup> of political life in France and the *parties civiles* influenced the use of these offences in the blood episode in France.

In the first set of proceedings in France, victims lodged complaints for *empoisonnement* and *administration de substances nuisibles* because they considered that these offences would respond better to their need for retribution as they were *crimes*, but the JI and the MP responded that these offences required the intention to kill or harm.<sup>47</sup>

But as victims were dissatisfied with the outcome of the first set of proceedings, regarding convictions for *tromperie* as inadequate, they decided to lodge other criminal complaints for *empoisonnement* and *administration de substances nuisibles* in 1993. The third set of criminal proceedings thus began. JI Bertella-Geffroy considered that *empoisonnement* and *administration de substances nuisibles* were appropriate to apply to the case because she argued that the only fact that the accused knew that the substance was deadly sufficed to constitute the *mens rea* of the offence.<sup>48</sup>

The prosecution was challenged by the *Cour de Cassation*'s decision in 1998<sup>49</sup> which held that *empoisonnement* required the proof of an intention to cause death or harm.<sup>50</sup> Consequently, in the course of the third set of proceedings, Bertella-Geffroy changed some of the charges and used *empoisonnement* for what she considered as the most culpable actions (see below), and *administration de substances nuisibles*, *violences volontaires*, *homicide involontaire*, *blessures involontaires* and *non-assistance à personne en danger* for the rest.<sup>51</sup> Actions subject to the charge of *empoisonnement* were the continuation of supply of contaminated products and the

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<sup>44</sup> L Greilsamer, above n11 at 18.

<sup>45</sup> See ch5 pt5.3.3, 148.

<sup>46</sup> See Ch1, 27.

<sup>47</sup> L Greilsamer, above n11 at 18.

<sup>48</sup> Interview with Marie-Odile Bertella-Geffroy (Paris, France, 18 January 2011) 6.

<sup>49</sup> Crim. 2 juill. 1998, Bull. Crim. N° 211, JCP 1998 II 10132.

<sup>50</sup> See Ch5, 129.

<sup>51</sup> A Thoraval, 'Pour la justice, l'affaire du sang n'a pas eu lieu', *Libération*, 19 juin 2003 ; TGI de Paris, Ordonnance de transmission du dossier et des pièces à conviction au procureur général et de non lieu partiel, D20917, 423.

prescription of contaminated blood products to PWH.<sup>52</sup> Proceedings ended in 2003 when the *Cour de Cassation* held that there was not enough evidence to hold the accused liable because at the time, there were still uncertainties on the risk of HIV-contamination and the reliability of HIV-tests and heat-treatment.<sup>53</sup> Moreover, the *Cour de Cassation* held that the accused was not necessarily aware of the deadly risk in blood products at the time.<sup>54</sup> Victims were outraged by the outcome of the third set of proceedings and thought that proceedings against ministers would respond to their need of justice.<sup>55</sup> They claimed that in the future, it would thus be lawful to kill for financial motives.<sup>56</sup>

The main issue concerned the mens rea of the offences of *empoisonnement* and *administration de substances nuisibles*.<sup>57</sup> These two offences were the only offences charged in the contaminated blood episode that were *crimes*, the highest degree of criminal offence in France which usually applies to ‘traditional’<sup>58</sup> criminal cases.<sup>59</sup> The question was whether or not *empoisonnement* and *administration de substances nuisibles* required the intention to cause death or injury and could apply to a failure to act against a contamination. Bouloc and Matsopoulou argued that it was difficult to believe that a person, who had knowingly administered a deadly substance to another, could not have had the intention to kill or harm.<sup>60</sup> Delmas Saint-Hilaire supported the same argument.<sup>61</sup> Some others argued that *empoisonnement* and *administration de substances nuisibles* only required the proof that the offender would give noxious substances to the victim, being aware of the fact that the substance would kill or harm the victim regardless of the result.<sup>62</sup> Danti-Juan on the other hand argued that *empoisonnement* was contained in a section of the *Code Pénal* on ‘murder and other capital crimes, menace against the person’.<sup>63</sup> Danti-Juan thus

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<sup>52</sup> TGI de Paris, above n51 at 26.

<sup>53</sup> Crim. 18 juin 2003 n° 02-85.199.

<sup>54</sup> Ibid.

<sup>55</sup> Unknown author, ‘Le sang contaminé empoisonne encore’, *Libération*, 5 juillet 2002.

<sup>56</sup> A Thoraval, ‘Sang contaminé : vers la cassation’, *Libération*, 8 juillet 2002.

<sup>57</sup> B Bouloc, H Matsopoulou, *Droit pénal général et procédure pénale* (18<sup>e</sup> edn, Sirey 2011) 103.

<sup>58</sup> See Ch5 n2, 124; I use the terms ‘traditional criminals’ to describe individuals who have a guilty intent to harm or deceive others for their own benefit.

<sup>59</sup> Art 301 ACP; art 318 ACP; MA Hermitte, above n10 at 397.

<sup>60</sup> B Bouloc, H Matsopoulou, above n57 at 103.

<sup>61</sup> J Pradel, above n10 at 53.

<sup>62</sup> Ibid 69.

<sup>63</sup> M Danti-Juan, ‘Sang contaminé, tromperie et empoisonnement, trop et trop peu n’est pas mesure’, in J Pradel (Dir.), *Sang et droit pénal. A propos du sang contaminé*, Travaux de l’Institut de sciences criminelles de Poitiers (Edition Cujas 1995) 65.

claimed that the French Parliament had meant for *empoisonnement* to be an intentional offence, just as murder for instance.<sup>64</sup> In his view, *empoisonnement* required the intention to cause death or at least bodily harm.<sup>65</sup> Judges had argued that in order to establish the intention to cause death, not only the knowledge of a deadly risk had to be proven, but also the existence of a confrontational relationship between the accused and the victims.<sup>66</sup>

I suggest that, as the *Cour de Cassation* held, *empoisonnement* and *administration de substances nuisibles* should require intent rather than a high degree of disregard. As Danti-Juan has argued, the two offences were part of a section in the *Code Pénal*, which included ‘murder and other capital crimes’.<sup>67</sup> *Empoisonnement* would thus require the intention to kill.<sup>68</sup> Even though the French *Code Pénal* did not explicitly require the intention to cause death or injury regarding *empoisonnement* and *administration de substances nuisibles* at the time, it seems that these two offences required an ‘active’ state of mind, an intention to do something ‘bad’.

The use of *empoisonnement* and *administration de substances nuisibles* was criticised by the media and some academics who held that the prosecution for *empoisonnement* was only meant to please the public and the victims to acknowledge the seriousness of the situation and convict those allegedly responsible of a *crime*.<sup>69</sup> One lawyer wrote that using the offence of *empoisonnement* in that context would mean that ‘judges would automatically charge the accused under the severe supervision of victims who quickly publicly denounce wrongdoers’.<sup>70</sup> JI Bertella-Geffroy even lodged a criminal complaint against a journalist for libel because he had claimed that the use of *empoisonnement* was outrageous and gave evidence of ‘judiciary demagogy’.<sup>71</sup> Others argued that *empoisonnement* was too ‘strong’ in comparison with actions committed by health officials.<sup>72</sup> Bertella-Geffroy argued that the MP was reluctant to prosecute for *empoisonnement* as this offence was too

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<sup>64</sup> Ibid 66.

<sup>65</sup> Ibid.

<sup>66</sup> Ibid 68.

<sup>67</sup> Ibid 66.

<sup>68</sup> Ibid 74.

<sup>69</sup> E Favereau, ‘La plainte d’une juge offensée. En charge du dossier du sang, Marie-Odile Bertella-Geffroy poursuivait le Monde’, *Libération*, 30 Septembre 1998 ; M Danti-Juan, above n63; O Beaud, above n10 at 46.

<sup>70</sup> D Soulez-Larivière, ‘Victimes et tragédies’, *Libération*, 16 juillet 2002.

<sup>71</sup> E Favereau, above n69.

<sup>72</sup> M Danti-Juan, above n63 at 61.



‘serious’ since it was a *crime*, and not a *délit* and thus was not considered appropriate to the failure committed by health officials in the blood episode.<sup>73</sup> The use of *empoisonnement* and *administration de substances nuisibles* also demonstrated the political dimension of the proceedings. It was argued that when failures in the health service occur, there is a need to identify politico-criminal liability and to use the criminal process as a special deterrent against the government.<sup>74</sup>

The nearest English equivalent of these two offences is the offence of administering noxious substances, contained in sections 23 and 24 of the Offences Against the Persons Act 1861 (OAPA 1861).<sup>75</sup> As I have demonstrated in Chapter 5, the English offence required the intention to cause harm whereas the French offences did not at the time of the proceedings.<sup>76</sup> Thus, the English offence could not have been used in that context as it required the intention to cause death which was not proven on the part of health officials.

The use of *empoisonnement* and *administration de substances nuisibles* in the French proceedings would have responded to the victims’ need for retribution and justice if the outcome of the proceedings had been successful. However, these three offences did not seem appropriate in the context of doctors and health officials negligently or even recklessly failing to inform Haemophilia patients that the products they were providing were contaminated with a deadly virus, delaying heat-treatment and donor screening and supplying contaminated blood to patients, simply because they had no intent to poison them. Even if *empoisonnement* and *administration de substances nuisibles* were only ‘attempts’ to cause death or harm, they would require the intention to *attempt* to cause injury or death. In the contaminated blood episode, however reckless doctors and health officials might have been in the decision-making process, they had no intention to cause the patients’ death. However, their disregard should amount to criminal behaviour in some parts of the decision-making process related to HIV-contamination of the blood supply, even though it is considered less severe than intentional conduct. Thus, offences appropriate to punish this type of conduct were, I argue in the next section, negligence offences.

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<sup>73</sup> Interview with Marie-Odile Bertella-Geffroy, above n48 at 6.

<sup>74</sup> D Viriot-Barrial, ‘Le droit pénal face aux grandes catastrophes sanitaires’ (2008) *Revue de droit sanitaire et social*, 21.

<sup>75</sup> A Ashworth, above n14 at 318.

<sup>76</sup> See ch5, 129.

The use of *empoisonnement* or *administration de substances nuisibles* in cases of healthcare malpractice would mean that there would be no difference between the situation where a wrongdoer had poisoned someone with intent to kill and a doctor who recklessly supplied contaminated blood products to his patients. Using *empoisonnement* or *administration de substances nuisibles* for both situations would thus mitigate the ‘seriousness’ of the offences and the role of the criminal law would thus not be fulfilled regarding deterring intentional wrongdoings such as poisoning.

### ***Violences Volontaires* and Causing Grievous Bodily Harm**

As explained in Chapter 5, *violences volontaires* was used in the third set of proceedings against doctors who had prescribed contaminated FCs to PWH when they knew of the risk of contamination in these products.<sup>77</sup> *Violences volontaires* did not require intention to cause death but it required intention to do the act that caused the harm. As set out in Chapter 5, its closest English equivalent was section 18 of the OAPA 1861, which, however, may require intent to harm and charges under section 18 would have been unlikely to succeed and were thus not appropriate in this context.

The use of *violences volontaires* did not lead to any conviction and was not subject to any commentary from the victims, media or academics. I suggest that *violences volontaires* seemed appropriate to apply to actions committed by doctors who had prescribed contaminated blood products to PWH in the blood episode. It was punished by 5 years imprisonment when the harm was committed on a person who was particularly vulnerable.<sup>78</sup> Thus, it acknowledged the status of patient and could have responded to the victims’ need for retribution if it had led to convictions. However, as *violences volontaires* is a *délit*, victims might not have seen it as sufficient in offering retribution.

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<sup>77</sup> TGI de Paris, above n51 at 349-387.

<sup>78</sup> Art 222-11 CP; art 222-12 CP.

### 6.2.2 Negligence Offences

In this subsection, I argue that negligence offences<sup>79</sup> would be more appropriate to apply to this context of failure to respond to a high risk of contamination in the national blood supply. Health officials had failed to provide proper care to Haemophilia patients. They could have acted earlier against the contamination but chose not to. It is important to note that most prosecutions for negligence offences were unsuccessful as they only resulted in two suspended jail sentences and an absolute discharge. Although they seemed to have been the best fit to apply in this context where there were failures to take appropriate measures against a massive contamination, there were some issues regarding their application, and the satisfaction of victims about the use of these offences as they did not see the actions committed by doctors and health officials as mere negligence. It is worth asking here whether the use of any offence could have satisfied the victims. From the evidence analysed so far, it seems that the only offence which could have satisfied the victims was *empoisonnement*.

### ***Non-Assistance à Personne en Danger* and Wilful Neglect**

The use of *non-assistance à personne en danger* only led to the conviction of Roux and Netter in the contaminated blood episode in France. Yet, it may have been the most appropriate offence in the contaminated blood case as it represented the attitude of the accused, as found by judges: the failure to act against the contamination and protect the patients. However, it only led to suspended jail sentences. Thus, even though the offence seemed to have been the best fit to apply in this context, it did not lead to many convictions which may show that the criminal law itself is not adapted to deal with this type of episode. This raises the question of whether the criminal law should ever play a role in ensuring that health officials do not neglect their duty. As noted in previous chapters, no equivalent to *non-assistance à personne en danger* has been found in English law, except for the very specific offence of wilful neglect

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<sup>79</sup> The terms ‘negligence offences’ are used here to include non intentional offences, regardless of the degree of negligence involved.

which only applies to mentally ill or incapacitated patients and so was unlikely to be of use in this case.<sup>80</sup>

*Non-assistance à personne en danger*, offence designed to criminalise negligent omissions, which I began to argue in Chapter 4, is a matter for the criminal law as long as it showed disregard for the health and safety of others at the level of recklessness, seemed therefore to have been the best fit to apply to the failure of health officials to protect PWH from HIV-contamination in blood products. It could apply whether another offence had been committed or not. In this particular case, judges used paragraph 1 of article 63 of the old *Code Pénal* (article 223-6 New *Code Pénal*) which stated that:

Will be punished from 3 to 5 years' imprisonment and fined 300 to 20000 Francs [...] anyone, who is able by his immediate action to prevent, without a risk to him or third parties, either a *crime* or a *délit* against the bodily integrity of a person, wilfully abstains from doing so.<sup>81</sup>

This raised the question of whether the other offence (*tromperie*) was an offence against the bodily integrity of a *person* (see previous subsection). Thus, if it was not, paragraph 2 of article 63 could have been used as it referred to anyone who wilfully abstained from providing assistance to a person in peril, 'without risk to him or third parties [...].'<sup>82</sup> Another advantage for the victims with the use of *non-assistance à personne en danger* was that it was not limited to victims who had died from AIDS and the causal link was easier to prove than for *homicide involontaire* (see subsection below).

### ***Homicide Involontaire* and Gross Negligence Manslaughter (GNM)**

Another offence which seemed to apply to the failures of health officials and doctors to respond to the HIV-contamination was *homicide involontaire*, which has an English equivalent.<sup>83</sup> It was used to prosecute three ministers in the *Cour de Justice*

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<sup>80</sup> See Ch5, 134.

<sup>81</sup> Art 63 al 1 ACP.

<sup>82</sup> Art 63 al 2 ACP.

<sup>83</sup> See Ch2, 42.

*de la République* (CJR) and in the third set of proceedings against some doctors and health officials.

*Homicide involontaire* also seemed to have been a good fit to actions that were committed by ministers and other doctors and health officials, but the main issue regarding *homicide involontaire* was that the causal link between the negligence and the death was hard to prove. A causal link had to be proven between decisions made by doctors or health officials and each patient's contamination. Thus, it was argued that the use of *homicide involontaire* required lengthy investigations on each accused and each victim.<sup>84</sup> It is worth noting however that *homicide involontaire* would have raised substantial practical problems in the sense that in each case, the patient's death would have to be linked with the defendant's negligence. If every case had to be pursued, there would have been thousands of prosecutions since there were thousands of victims.

Unlike *tromperie* and without the need to use a *crime*, *homicide involontaire* would have acknowledged the 'homicidal dimension' that victims had asked for and thus perhaps responded to their need for retribution.<sup>85</sup> However, the details of laws of causation can be hard to understand and victims may have seen the prosecutions for *homicide involontaire* as failing to meet their just demands for retribution. In the one case where the prosecution was successful, victims were outraged that Hervé was given an absolute discharge.<sup>86</sup>

The English equivalent of *homicide involontaire*, gross negligence manslaughter (GNM), which I have suggested, seemed to have been the basis of the only CPS investigation in England, could have been appropriate to use in the blood episode, but the same causation issues would have had to be addressed. Moreover, gross negligence would have to be proven, which I showed in Chapter 2, was sometimes difficult given the uncertain and circular test of gross negligence in England. However, GNM could perhaps have responded to retribution needs better because it allows longer prison sentences than *homicide involontaire* although such sentences are not necessarily imposed in practice in the healthcare context.

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<sup>84</sup> M Bernard-Requin, 'SIDA et transfusion sanguine ou l'affaire du sang contaminé. Les difficiles qualifications pénales' (1998) 28(1) *Médecine et Maladies Infectieuses*, 20.

<sup>85</sup> MA Hermitte, above n10 at 374.

<sup>86</sup> A Thoraval, 'Le procès du sang contaminé. Du sur-mesure illégal. La dispense de peine d'Edmond Hervé est une hérésie', *Libération*, 10 mars 1999.

### ***Blessures Involontaires* and Reckless Grievous Bodily Harm (GBH)**

*Blessures involontaires*, another offence used in the context of healthcare malpractice in France, was used to prosecute health officials and ministers in the second and third sets of proceedings in the blood episode in France.<sup>87</sup> These charges only applied in the case of victims who had been contaminated with HIV but had not developed AIDS or victims who had developed AIDS but were still alive. Once again, the use of this offence, which although was appropriate to apply to the failure to respond to the contamination as it was designed to criminalise negligently causing harm, was not seen by the victims as successful to meet their demands for justice and retribution. In this context, section 20 of the OAPA 1861 would have been appropriate to use in the case of reckless conduct and I will discuss in next chapter whether section 20 could and should be used in the context of healthcare malpractice.

This section has shown that neither intentional offences nor negligence offences responded to the victims' need for retribution. Negligence offences seemed to have been the most appropriate to apply to the failure of health officials and ministers to take relevant measures against the contamination of blood products. However, they were unsuccessful at meeting the victims' needs for retribution, justice and accountability. Danti-Juan argued that negligence offences were the most appropriate to use in the blood case.<sup>88</sup> Actions committed by doctors, health officials and ministers in the contaminated blood episode were very similar to a road traffic accident where someone drives a car, which he knows is in bad shape and causes harm to others. Intentional offences would not be used in that context.

However, negligence offences might not have emphasised the fact that blood authorities had delayed heat-treatment, donor screening and had supplied contaminated blood products to patients in order to make profit and save money, which is mainly what had motivated the victims and the courts to use intentional offences in France, to emphasise that they had given priority to profit rather than to

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<sup>87</sup> See Ch5, 137.

<sup>88</sup> M Danti-Juan, above n63 at 75.

patient safety. Thus perhaps, as Danti-Juan has suggested, negligence offences aggravated by *mise en danger délibérée* could have been appropriate today.<sup>89</sup>

Wilful neglect (if it was extended to all patients receiving care), reckless wounding (if it was used in the healthcare context) and GNM could potentially have applied to the failure of health officials and doctors to take prompt measures to stop the contamination. But as explained in Chapter 2, English prosecuting authorities would have been more reluctant to prosecute for charges other than GNM in the healthcare malpractice context. The little evidence of the one very brief CPS investigation conducted in 2002/3 may indicate that the CPS did not see criminal law as an effective response to the episode. Nevertheless, negligence offences did not emphasise the fact that actions committed by doctors, health officials and ministers had caused multiple victims.

A lawyer claimed that ‘the real problem posed by involuntary offences is that of the victim. Her misfortune is so great that her desire to dictate what the criminal process should be, where everything that does not go according to her desire is unacceptable, becomes legitimate’.<sup>90</sup> Intentional offences seemed to have responded better to victims’ demands for justice than negligence offences because they were more ‘serious’, although their outcome did not satisfy the victims. Thus, there was an acknowledgement that something bad had happened and a ‘crime’ has been committed. Negligence offences did not have long enough sentences, according to victims.<sup>91</sup> *Empoisonnement* was the most ‘effective’ offence used in the blood episode that could have fulfilled the victims’ demands for justice and retribution, but it did not lead to any convictions. Perhaps in England, GNM would have responded to victims’ demands for retribution and justice more effectively than French negligence offences because it might be punished by life imprisonment. The only issue with the use of *homicide involontaire* and GNM was that these offences would have only applied to dead victims. However, as we know, some victims with AIDS were still alive at the time of the proceedings, others had not yet developed the disease. Thus, perhaps the use of *blessures involontaires* or reckless grievous bodily harm from section 20 of the OAPA 1861 could have addressed this issue.

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<sup>89</sup> Ibid 77.

<sup>90</sup> D Soulez-Larivière, above n70.

<sup>91</sup> E Favereau, ‘Sang contaminé: vers un troisième procès’, *Libération*, 27 mars 2002.

## **Corporate Offences and Health and Safety Offences**

As shown in Chapter 5, health and safety offences could have applied to acts or omissions committed by blood officials in both countries.<sup>92</sup> However, would they have responded to the victims' need for retribution? We could argue that as regulatory offences, the desire for retribution of victims would not have been fulfilled if health and safety offences had been used. However, corporate offences and health and safety offences could have responded to difficulties relating to proving a causal link and the claims made by the accused and commentators that the individuals were singled out and the criminal process had only been used as a show trial. Moreover, the use of corporate manslaughter could have ensured prevention of similar healthcare disasters, because, as will be shown in the next chapters, the Corporate Manslaughter and Corporate Homicide Act 2007 (CMCH 2007) contain orders of publicity and compliance by health institutions. I will however argue that corporate criminal liability is not always the answer to addressing healthcare malpractice.

### **6.3 Usefulness of the Criminal Process as a Response to the HIV-Contaminated Blood Episode**

Victims of healthcare malpractice in France see many advantages in using the criminal process, in terms of accessing to compensation, holding defendants to account and providing with an understanding of what happened, the 'truth'. In this section, I compare the outcome of the legal responses given to the blood episode in England to the outcome of criminal proceedings in France. The comparison will help shed light on whether the criminal process was a useful response to the episode in terms of ensuring blood safety and responding to victims' demands. The aim of this section is to determine when criminal law should play a role in healthcare malpractice episodes, whether lessons can be learnt from the use of the criminal process in that context and whether features of the French criminal process could strengthen other responses to healthcare malpractice.

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<sup>92</sup> See ch5, 138.



Some of what the criminal process does might address issues related to healthcare safety and responses to victims' demands. For instance, deterring failure or incapacitating negligent healthcare professionals could ensure safety in the healthcare context. But as will be shown in this section, the criminal process seemed to have been limited in ensuring healthcare safety and responding to victims' demands in the blood episode. But the French criminal process proved to be useful in terms of investigation and transparency. I begin to propose that effective investigation processes and in some cases of great gravity, public inquiries might achieve some of what the French process can do. This will be illustrated by the analysis of the Archer Inquiry as used in the blood episode, although its limitations will be noted. Moreover, I will begin to argue that other mechanisms could have responded to these aims more appropriately than the criminal process. However, I will show that some features of the French inquisitorial criminal process could be borrowed and used in other proceedings to ensure that these aims are properly fulfilled.

### **6.3.1 Deterrence and Prevention**

This subsection demonstrates that the criminal process was limited in terms of deterring and preventing malpractice in the health service following the blood episode in France. I argue that inquiries such as the Archer Inquiry may have been more appropriate to respond to the episode in terms of prevention. However, the Archer Inquiry had limits as it was not timely, lacked legal power and powers of implementation, and a public inquiry could have been more appropriate.

There is little evidence that criminal proceedings arising out of the blood scandal in France deterred doctors, health officials and ministers from committing the same errors or got them to admit responsibility.<sup>93</sup> Most proceedings did not lead to any convictions but even unsuccessful prosecutions could have had a deterrent effect on other doctors, health officials and ministers as they witnessed the negative impact of the prosecutions on the accused's careers. However, without firm evidence, it is difficult to assess the deterrent effect of the prosecutions in the blood episode.

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<sup>93</sup> Interview with A (Cambridge, United Kingdom, 3 February 2011) 23-24.

The proceedings seemed to have had the opposite outcome on other healthcare professionals. A significant number of doctors and scientists from different countries including Nobel prizes supported the accused and asked for the pardon and the release of Garetta and Allain to President François Mitterrand.<sup>94</sup> This shows that a significant number of doctors and scientists were not ready to acknowledge that an offence had been committed by the two doctors or that they viewed the conviction as unjust to doctors who had shown good practice for so many years.

In terms of prevention, again it is difficult to assess the benefits of the criminal process given the lack of clear evidence. Following the blood scandal in France, new developments occurred in the area of healthcare malpractice/accidents, for instance, the precautionary principle and the reorganisation of the blood supply with the creation of the *Agence Française du Sang* in charge of supervising blood centres and coordinating their action as well as the creation of the *pôles de santé publique*.<sup>95</sup> There is no clear evidence that the use of the criminal process did actually result in these reforms. The combination of the scandal and the use of criminal proceedings as well as Parliamentary inquiries conducted by the *Sénat* and the *Assemblée Nationale* may have had an effect on these reforms.<sup>96</sup> Following the blood episode, healthcare scandals still occurred, which could suggest that the episode and the use of the criminal process did not help preventing further healthcare failure. One of the most recent healthcare malpractice episodes was the ‘Mediator’ episode in France, which concerned the supply by Servier Laboratory of a diabetes medicine which caused the death of hundreds to thousands of patients. Criminal complaints were lodged for *tromperie*, *mise en danger délibérée*, *administration de substances nuisibles*, *homicide involontaire*, and *blessures involontaires*.<sup>97</sup> Investigations are being conducted by Bertella-Geffroy. Similarly, the head of the company which manufactured defective breast implants (Poly Implant Prothèse) was jailed for *blessures involontaires* in early 2012.<sup>98</sup> The implants were made of low-grade

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<sup>94</sup> A Dorozynski, ‘France split on pardons over tainted blood’ (1994) 308(6924) *British Medical Journal* 294.

<sup>95</sup> Interview with Dominique Marchetti (Paris, France, 17 January 2011) 7; J Sourdille, C Huriet, *La crise du système transfusionnel français*, Rapport de la commission d’enquête du Sénat (Economica 1992); A Thoraval, ‘Une juge lassée’, *Libération*, 3 mai 2001; J Coignard, ‘Un pôle de santé crée au palais de justice de Paris’, *Libération*, 27 juin 2001; Interview with A above n93 at 22.

<sup>96</sup> O Beaud, above n10 at 41.

<sup>97</sup> Unknown author, ‘116 plaintes déposées au Tribunal de Paris’, *Le Monde*, 11 janvier 2011.

<sup>98</sup> Unknown author, ‘Prothèse PIP: Jean-Claude Mas incarcéré’, *L’Express*, 6 mars 2012.

industrial silicone and could rupture and leak.<sup>99</sup> Approximately 30,000 women in France and 400,000 to 500,000 women in other countries have PIP breast implants and are thus at risk of rupture and possibly cancer.<sup>100</sup> Three other executives of the company were prosecuted for *homicide involontaire* and *blessures involontaires* in France.<sup>101</sup> This suggests that even after the blood scandal and despite prosecutions and convictions of health officials, healthcare malpractice episodes still happen and the deterrent effect of the criminal process in that area should be questioned. However, it could also suggest that the use of the criminal process in the blood episode had a deterrent effect on health officials working in the public sector but not on managers or heads of private laboratories. The criminal process was useful in the sense that criminal investigations conducted by JIs did provide substantial information on the decision-making process of blood authorities which could have been used to analyse systemic failure and set up prevention measures.

The Archer Inquiry had more potential in terms of prevention and healthcare safety. It recognised that the contamination was the result of a disorganisation and malfunction of the blood supply organisation. Furthermore, the inquiry proposed a number of measures to be taken by authorities to respond to victims' demands in the case of future contaminations, or to prevent future contaminations.<sup>102</sup> The main limit of the Archer Inquiry was that it had no legal power and thus most of its recommendations were not followed by English health authorities.

Archer proposed measures to respond better to victims' demands but these measures were not preventive measures and did not act on the inherent problems that caused the contamination. The Inquiry did not recommend actions to review or improve the system and its recommendations only applied to PWH and the contamination of blood, they cannot generally apply to all cases of healthcare 'accidents'. The inquiry recommended that Haemophilia patients who had received blood products and their partners as well as blood donors be tested.<sup>103</sup> Infected patients should be provided free prescription drugs and GP visits, counselling, physiotherapy, home nursing and

<sup>99</sup> Unknown author, 'PIP breast implant boss Jean-Claude Mas faces charges', *BBC News*, 27 January 2012.

<sup>100</sup> Unknown author, 'Prothèses mammaires PIP : Chronologie d'un scandale', *Le Monde*, 9 mars 2012.

<sup>101</sup> Unknown author, 'PIP: Trois cadres de la société varoise mis en examen', *L'Express*, 29 février 2012.

<sup>102</sup> Rt Hon Lord Archer of Sandwell QC, above n5 at 107-110.

<sup>103</sup> Ibid 108.

support services.<sup>104</sup> The report also insisted on the necessity for the Government to fund the Haemophilia Society adequately.<sup>105</sup> The inquiry also pointed out the importance of the relationship between doctors and patients and the information given to patients on the risk of healthcare procedures. The Archer Inquiry emphasised the need to give PWH free ‘adequate health and support services’.<sup>106</sup> According to the inquiry, patient representation was necessary for both the healthcare system and patients.<sup>107</sup> The Government proposed that developments be made on the existing Haemophilia Alliance, which contains patients and Haemophilia doctors, chaired by the Haemophilia Society and the Haemophilia doctors’ organisation.<sup>108</sup> As a response to Archer’s recommendations, the Government held that tests would be offered to patients. As regards free treatment, the Government stated that free prescriptions were part of the ‘Government’s policy intentions on prescription charges in England’, GP visits, counselling, physiotherapy and home nursing were ‘already available in England when needed’.<sup>109</sup> Other recommendations concerned the need for transparency and patient representation as well as financial support for victims of the contamination. But as will be shown later in this chapter, the DH did not respond effectively to all Archer’s recommendations.

### 6.3.2 Accountability

Holding people to account for something that went wrong in a healthcare service where there is evidence of moral culpability could be a way to ensure healthcare safety and respond to the victims’ need for ‘justice’. In the blood episode, the use of the criminal process had more potential in holding people to account than the Archer Inquiry and civil proceedings did.

In each set of criminal proceedings in France, JIs identified individual liability and established a causal link between each accused’s action and each *partie civile*’s death or harm. The role of JIs and the MP was particularly crucial in holding people to

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<sup>104</sup> Ibid.

<sup>105</sup> Ibid.

<sup>106</sup> Ibid 97-98.

<sup>107</sup> Ibid 98.

<sup>108</sup> Department of Health, above n5 at 9.

<sup>109</sup> Ibid 10.

account in the proceedings. They identified individuals at fault and held some of them to account.

The Archer Inquiry analysed the blood episode with regard to HIV and Hepatitis C contaminations and acknowledged that some failures were committed in the blood episode in England. For instance, it demonstrated that the decision-making process on donor screening and HIV-testing was a slow process.<sup>110</sup> However, contrary to criminal proceedings in France, it did not identify individuals who were liable for failing to respond to the contamination. Archer declared that ‘we have not gone out of our way to apportion blame, it is a bit late and perhaps a bit pointless to say who is to blame when it is too late to do much about it’.<sup>111</sup> This again suggests that the need for developing prompt and effective inquiries is even more crucial when a massive failure of the whole system has occurred because of the complexity of the event and the disastrous outcome. There is a need for conducting formal public inquiries in a timely manner with means of investigation and compliance, and the making of recommendations that would have to be implemented by health institutions promptly. The Haemophilia Society was not satisfied with the English Government’s response to the Archer Inquiry’s recommendations because the Government did not implement the recommendations in full and did not acknowledge responsibility on the part of health authorities: the DH was ‘incapable of the simple human compassion and understanding required to deal with the victims of the disaster’.<sup>112</sup> Lord Archer denounced the response of the Government as ‘deeply disquieting’ and a ‘faltering step that only compounds the anguish of the afflicted and bereaved’, he declared that ‘it [was] difficult to avoid the conclusion that humanitarian impulses have come a bad second to Treasury constraints’.<sup>113</sup>

In October 2010, Members of the Parliament in the House of Commons debated the response that should be given to PWH victim of the contamination.<sup>114</sup> Members of the Parliament recognised the responsibility of health authorities. They added that ‘successive governments irrespective of their persuasion hesitated over investing resources and setting precedents. They were all equally culpable in failing the

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<sup>110</sup> Rt Hon Lord Archer of Sandwell QC, above n5 at 59.

<sup>111</sup> G Katz, ‘No Individual Blame in UK’s Tainted Blood Scandal’, *ABC News International*, 23 February 2009.

<sup>112</sup> Haemophilia Society React to Government Response to The Archer Report, date unknown.

<sup>113</sup> G Colthart, above n5.

<sup>114</sup> HC Deb, above n5.

victims'.<sup>115</sup> It was held that the Government should take Lord Archer's recommendations seriously and implement more of them.<sup>116</sup>

Civil proceedings arising out of the blood contamination in England ultimately failed in terms of a judgment for the plaintiffs as they ended in settlement. They neither fulfilled the victims' needs for compensation nor in the light of obstructive government did they provide a degree of accountability that a tort action might normally offer. As mentioned in Chapter 4, the plaintiffs were suing the defendants (including Department of Health (DH), Regional Health Authorities (RHAs) and the Central Blood Laboratory Authority) for negligence and breach of statutory duty. The DH claimed that there could be no cause of action against the DH for breach of statutory duty according to the National Health Services Act 1977 (NHS Act 1977) and the Medicines Act 1968 and that any duty that the DH owes is owed to the whole public, not to individual plaintiffs.<sup>117</sup> Ralph Gibson LJ (which Bingham LJ and Sir John Megaw agreed to) held that, even though the NHS Act 1977, which the plaintiffs relied upon, imposed a duty on the Secretary of State for Health, it did not imply that this duty may be enforced by individuals in a civil court.<sup>118</sup> Thus, he decided that there was no breach of duty or negligent breach of duty that the plaintiffs could claim.<sup>119</sup>

After the Court of Appeal's decision, even though a full trial was planned to take place in March 1991, Mr Justice Ognall asked the parties to settle the litigation.<sup>120</sup> Regional health authorities and Secretary of State for Health met in order to agree on their arguments for the settlement.<sup>121</sup> The Health Secretary initially refused to settle the case claiming that the Government did not owe a duty of care to PWH.<sup>122</sup> But he finally agreed in December 1990, on the condition that civil proceedings were ended.<sup>123</sup> The settlement was of £42M and the plaintiffs were paid legal costs but the defendants still denied liability.<sup>124</sup> The settlement payment was included in the

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<sup>115</sup> HC Deb, 14 October 2010, vol 516, col 538.

<sup>116</sup> HC Deb, 14 October 2010, vol 516, col 539.

<sup>117</sup> *HIV haemophilic litigation* [1990] 41 BMLR 171 at 177.

<sup>118</sup> 41 BMLR 171 at 188.

<sup>119</sup> 41 BMLR 171 at 181.

<sup>120</sup> Mr Justice Horace Kever, above n3 at 942.

<sup>121</sup> *Ibid.*

<sup>122</sup> C Dyer, above n43.

<sup>123</sup> Mr Justice Horace Kever, above n3 at 942.

<sup>124</sup> *Ibid.*

Macfarlane Trust.<sup>125</sup> In March 1991, each of 1226 persons registered in the Trust was paid £35000.<sup>126</sup> However, the plaintiffs had to renounce to any legal action against the defendants.<sup>127</sup> Haemophilia patients saw the settlement as ‘a gesture rather than a settlement’.<sup>128</sup> Civil proceedings in England failed to bring closure to the victims in England and failed to hold someone accountable for the failure to respond to the contamination.<sup>129</sup>

In England, civil proceedings and the Archer Inquiry did not identify allegedly responsible people in the contamination and did not acknowledge any negligence or failure to act on the part of individual doctors, health officials or ministers even though some failures were recognised in the Archer Inquiry.

### 6.3.3 Incapacitation and Rehabilitation

Incapacitation and rehabilitation, some of the general aims of the criminal law, may also ensure good healthcare practice when there was evidence of culpable disregard to the life of patients. In the blood episode, the criminal process incapacitated only the persons who were actually jailed, so overall only 2 doctors out of the 39 people prosecuted in the proceedings. The accused generally felt that they were used as scapegoats and some of them even published books in which they defended their position.<sup>130</sup> Disciplinary proceedings are usually more effective to achieve incapacitation and rehabilitation than the criminal process in the healthcare context. However, most errors observed in the blood episode were committed by health officials as part of their function and disciplinary proceedings would not have been useful in that context because health officials would not be subject to disciplinary proceedings. The criminal process would perhaps have been more useful. However,

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<sup>125</sup> See pt6.3.6.

<sup>126</sup> Mr Justice Horace Krever, above n3 at 942.

<sup>127</sup> HIV Haemophilia Litigation, Main settlement agreement, 24 April 1991.

<sup>128</sup> S Boseley, ‘Increased offer for NHS patients infected with hepatitis C “disappointed”’, *The Guardian*, 10 January 2011.

<sup>129</sup> Ibid.

<sup>130</sup> O Beaud, above n10 at 43 ; JP Allain, F Prat, *Le Sida des hémophiles* (Frison-Roche 2000) ; J Roux, *Sang contaminé : priorités de l’Etat et décisions politiques* (Editions Espace 34 1995).

we should note that political accountability could have achieved incapacitation and rehabilitation of ministers.<sup>131</sup>

#### **6.3.4 Retribution**

When something terrible has happened, victims usually demonstrate a desire for some kind of retribution. As demonstrated in the previous chapter, it was one of the demands expressed by victims of the blood episode in both countries.<sup>132</sup> Only the criminal process can provide retribution to victims. But in this particular episode, some of the victims' demands for retribution could only be justified in cases where there was a level of failure that should have engaged the criminal law.<sup>133</sup>

Only the criminal process responded to the need for retribution, whereas the Archer Inquiry and civil proceedings did not. Criminal proceedings arising out of the blood episode in France put doctors, health officials and ministers on the spot. They were 'accused', 'criminals'. JIs identified individual responsibilities and charged the accused accordingly. The Archer Inquiry and civil courts acknowledged that some failures had occurred, although they did not point the finger on any particular individual. However, victims were unhappy with the outcome of the proceedings in France which were then insufficient to meet their demands.

#### **6.3.5 Transparency and Closure**

Transparency on the blood contamination was important to victims as they wanted to understand what had happened in order to have some kind of closure. Victims claimed that they needed explanations and apologies from the accused.<sup>134</sup> Transparency was crucial in preventing similar healthcare disasters and ensuring blood safety after the episode.

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<sup>131</sup> O Beaud, above n10 at 112.

<sup>132</sup> See ch5 pt5.3.1, 140.

<sup>133</sup> See ch4.

<sup>134</sup> A Thoraval, 'Toutes les victimes doivent porter plainte', *Libération*, 9 juillet 2002 ; J Perrignon, 'Le procès du sang contaminé. « Ils se foutent du monde ». Désabusées ou révoltées, les victimes s'insurgent contre le flou et le manque de pertinence des débats' *Libération*, 24 février 1999.



As demonstrated in Chapter 3, the French inquisitorial process offers in-depth investigations.<sup>135</sup> Because JIs have wide coercive powers (in particular the power to seize documents), they were able to access confidential documents relating to policy-making in the blood episode by health institutions and blood centres. JIs also resorted to the police to find more evidence (third set of proceedings). To determine the level of knowledge on HIV/AIDS of the accused, JIs used scientific documents such as scientific journal articles, or heard witnesses who were mainly doctors or scientists and the accused.<sup>136</sup> To determine if the accused had committed a wrong, JIs looked at administrative services documents such as notes, correspondence between officials, minutes of meetings and circulars, which showed that there had been delays in taking measures against the contamination for profit reasons when these measures could have been taken much earlier. JIs did not rely heavily on experts except in the third set of proceedings, but most witnesses acted as experts since they were all scientists and experts on HIV/AIDS or Haemophilia.<sup>137</sup> Criminal investigations provided very precise information on the decision-making process of blood centres officials and health authorities and thus highlighted the malfunctioning of the system and individual failures and negligence.<sup>138</sup>

However, criminal investigations and proceedings went on for 15 years. It was argued that the ‘French inquisitorial procedure had once again shown its archaism, its slowness and its polymorphous inefficiency’.<sup>139</sup> I argue that rather than using criminal law, the means of investigations used in criminal proceedings in France should be copied in alternative proceedings in England in the context of healthcare malpractice.<sup>140</sup>

While criminal proceedings in France permitted the disclosure of substantial information on the case, accessing administrative documents in England was much more difficult. The DH refused to provide witnesses to give evidence at the Archer Inquiry. However, the DH supplied documents, answered questions and attended

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<sup>135</sup> See ch3 pt3.4.1, 71.

<sup>136</sup> TGI de Paris, above n51 ; Commission d’instruction de la CJR Arrêt portant renvoi devant la CJR, 17 juillet 1998, D6137. L Greilsamer, above n11.

<sup>137</sup> Ibid.

<sup>138</sup> Interview with Dominique Marchetti (Paris, France, 17 January 2011) 6.

<sup>139</sup> D Soulez-Larivière, above n70.

<sup>140</sup> It was proposed in France to ‘redefine civil procedures which are naturally here to receive victims’ claims and to get clarification on the tragedies they have experienced’. See D Soulez-Larivière, above n70.

meetings.<sup>141</sup> The Archer Inquiry reviewed over 20,000 documents, and information contained in 300 witnesses' statements, of which 64 were oral statements.<sup>142</sup> The information collected in the Inquiry covered the four areas analysed in the three sets of criminal proceedings in France: the level of knowledge about HIV/AIDS in scientific and political circles, monetary issues of the blood supply and self-sufficiency, the measures taken to stop or reduce the contamination of PWH and blood recipients and the information about HIV risk of contamination from doctors to patients.<sup>143</sup> It used witness statements which were not used in civil proceedings. The Inquiry sought to make a compromise between victims' demands and health authorities' interests. It was impartial and independent: 'we are as independent of the Government as we are of the Haemophilia Society'.<sup>144</sup> It provided a good understanding of the actions occurred during the contamination and the demands of victims and recommended fair measures for PWH. However, the inquiry did not have access to numerous documents which could have been crucial to demonstrate errors made by health authorities during the contamination, for example, minutes of health authorities meetings and administrative notes that could have helped emphasising the failure of English health authorities to respond to the contamination. This type of documents was accessible to JIs in France.

Some of Archer's recommendations could have ensured transparency and closure for blood patients. For example, Lord Archer proposed the establishment of a statutory advisory committee, which would represent its members and ensure the involvement of Haemophilia patients in decisions regarding their treatment because 'good practice in health care provision involved patient representation' to provide the victims and the Haemophilia community the closure they wanted.<sup>145</sup> The Inquiry also insisted on the necessity of transparency of the service.<sup>146</sup> The Archer report also stated the need for an apology to victims on the part of the State which they actually never obtained.<sup>147</sup>

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<sup>141</sup> Rt Hon Lord Archer of Sandwell QC, above n5 at 9.

<sup>142</sup> Ibid 7.

<sup>143</sup> Ibid 10-21, 47-53, 26-46, 47-59, 60-66.

<sup>144</sup> Ibid 8.

<sup>145</sup> Ibid 96, 107.

<sup>146</sup> Ibid 99.

<sup>147</sup> Ibid 101.

As for providing the victims with information on what had happened during the contamination, the Government stated that it had released over 5500 documents and was still releasing documents, as some of them were missing.<sup>148</sup> As for setting up a statutory advisory committee, the Government argued that it was ‘better to build on existing arrangements and expertise, rather than risk disrupting or duplicating those arrangements via legislation’.<sup>149</sup> The Government’s response to these recommendations shows that the Archer Inquiry was insufficient in terms of ensuring transparency and closure. Perhaps if the inquiry had legal powers, the Government would have responded to the recommendations more appropriately. This suggests that a public inquiry conducted in a timely manner could have been more efficient.

In the *HIV Haemophiliacs Litigation*, the plaintiffs had asked the DH to disclose documents that could prove that the DH had knowingly pursued the supply of contaminated FCs. The DH initially refused, arguing that the documents did not contain evidence of breach of duty on the part of the DH.<sup>150</sup> The Ministry of Health, in July 1990, gave the plaintiffs the list of documents which were protected by public interest immunity but refused to hand them over.<sup>151</sup> The list contained around 600 documents from between 1972 and 1986.<sup>152</sup> The documents were similar to those found in criminal proceedings in France. They included submissions to ministers and exchanges with ministers, documents on self-sufficiency policy, financial issues and resources relating to self-sufficiency, plans to improve the Blood Products Laboratory (BPL), donor screening, heat-treatment, documents prepared by civil servants on policy plans, and briefing notes to ministers prior to meetings with blood institutions. The plaintiffs then asked for the disclosure of these documents.<sup>153</sup>

On the 31 July 1990, Rougier J in the High Court ordered the production of some documents because the case was of ‘such gravity’.<sup>154</sup> He ordered the disclosure of only documents related to policy decisions on the safety of blood products between 1972 and 1986.<sup>155</sup> Documents on self-sufficiency, the BPL and heat-treatment were

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<sup>148</sup> Department of Health, above n5.

<sup>149</sup> Ibid 9.

<sup>150</sup> See ch5.

<sup>151</sup> 41 BMLR 171 at 174.

<sup>152</sup> 41 BMLR 171 at 177.

<sup>153</sup> Mr Justice Horace Krever, above n3 at 941.

<sup>154</sup> 41 BMLR 171 at 183.

<sup>155</sup> Ibid.

not disclosed.<sup>156</sup> Appeal was raised by the plaintiffs to ask for disclosure of all documents which related to major matters of policy including financial issues and resources relating to self-sufficiency and the BPL. Cross appeal was brought by the DH on the grounds that all documents should not be disclosed because there was no valid cause of action and the documents were protected by public interest immunity.<sup>157</sup> Disclosure was crucial as it could have proven that the DH had committed negligence in the episode.<sup>158</sup> On the contrary in France, the documents that JIs used in France permitted to prove that some of the actions committed by doctors and health officials demonstrated moral culpability.

On 20 September 1990, the Court of Appeal stated that the DH had committed ‘grave errors of judgment’ and that it had failed to protect the plaintiffs from a contamination, which was the result of a ‘failure to act appropriately upon available information’.<sup>159</sup> Thus, the Appeal Court argued that the documents requested by the plaintiffs were likely to demonstrate the failure of the defendants in protecting the plaintiffs from HIV-infection. The public interest in a fair trial for the injured plaintiffs outweighed public interest immunity.<sup>160</sup>

Ralph Gibson LJ held that the plaintiffs needed to have access to almost all the documents for the ‘proper presentation of their case’ in the tort of negligence as to understand the alleged failure that, the judge admitted, happened in fact.<sup>161</sup> The Court of Appeal ordered the production of all documents regarding self-sufficiency, the organisation of the National Blood Transfusion Service (NBTS) and the BPL, donor screening, HIV-testing and heat-treatment.<sup>162</sup> We should note however that a number of documents were destroyed between 1990 and 1998 in relation to the Advisory Committee on the Virological Safety of Blood.<sup>163</sup> An investigation by Internal Audit was conducted in 2000 regarding the loss of these documents. Claimants were PWH who had been infected with HIV and Hepatitis C as a result of treatment with FCs or

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<sup>156</sup> Ibid; Mr Justice Horace Krever, above n3 at 941.

<sup>157</sup> HIV Haemophilic Litigation, Court of Appeal, 20 Septembre 1990; 41 BMLR 171 at 174 and 184.

<sup>158</sup> Rt Hon Lord Archer of Sandwell QC, above n5 at 6.

<sup>159</sup> 41 BMLR 171.

<sup>160</sup> 41 BMLR 171 at 173.

<sup>161</sup> 41 BMLR 171 at 195.

<sup>162</sup> Ibid; Mr Justice Horace Krever, above n3 at 942.

<sup>163</sup> Department of Health, Review of Documentation Relating to the Safety of Blood Products 1970-1985 (Non A Non B Hepatitis), May 2007.

blood transfusions.<sup>164</sup> The report concluded that an inexperienced member of administration was responsible for the destruction.<sup>165</sup>

Civil proceedings permitted the disclosure of crucial documents for Haemophilia patients and more than 900 victims had access to civil proceedings and disclosed documents. It might have provided them with a certain understanding of what had happened. Documents disclosed in the civil litigation were very similar to the documents used by criminal courts in France in the three sets of criminal proceedings, but in the civil litigation, judges did not analyse the decision-making process of health authorities mainly because the case never went to full trial. In France, even before the trials, information collected by JIs permitted to shed light on what had happened.

However, JIs did not identify or analyse possible deficiencies in the blood organisation so as to propose solutions to the problem, as the Archer Inquiry did. Yet, Marchetti claimed that the work of JIs in France was crucial in understanding what had happened and the chain of decisions in the blood episode and in giving closure to victims.<sup>166</sup> Civil proceedings did not provide with recommendations either. On the contrary, the Archer Inquiry recognised that the contamination was the result of a disorganisation and malfunction of the blood supply organisation. Yet, as shown above, most recommendations in the inquiry were not followed by English authorities.

The advantage of criminal proceedings in France was that JIs heard the accused and had access to a wider range of documents thanks to their powers of investigation<sup>167</sup> in early stages of the proceedings. The use of experts in the third set of criminal proceedings in France to determine CNTS financial situation, the number of victims and the causal link between the supply of contaminated FCs and HIV-contamination of the victims was crucial. However, the criminal process did not go beyond proving individual culpable failure because it did not look at systemic issues. Nevertheless, it is worth noting that proceedings for corporate offences could have looked at systemic issues.

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<sup>164</sup> Department of Health, Internal Audit Review Hepatitis C Litigation Final Report, April 2000, 3.

<sup>165</sup> Department of Health above n163 at 4.

<sup>166</sup> Interview with Dominique Marchetti, above n95 at 6.

<sup>167</sup> See ch3 pt3.4.1, 71.

The Archer Inquiry and civil proceedings in England lacked expert reports and this perhaps explains why no individual could be held accountable, although this is not proven. Indeed, Beaud argued that criminal proceedings in France also lacked the use of expert reports as they were only used in the third set of proceedings.<sup>168</sup> The Court of Appeal in the first set of criminal proceedings argued that hearings of scientists as witnesses who played a similar role as experts, were sufficient to learn on the level of knowledge of doctors and scientists on HIV/AIDS at the time.<sup>169</sup> But Beaud raised an important issue: ‘if health officials and ministers needed experts to understand blood transfusion, why would judges not need experts too?’<sup>170</sup>

In England, the Archer Inquiry may have provided the victims with a certain understanding of what had happened. However, JIs may have had a greater access to documents and information than Lord Archer but perhaps not greater than a proper public inquiry carried out in a timely fashion. The Inquiry was independent and financed by private donations whereas the cost of investigations conducted by JIs was supported by the justice system. Thus, the means of investigation used in the Inquiry might have been more limited than in an investigation conducted by a JI who may use police services if needed. Moreover, even though the Archer Inquiry may have responded to the victims’ need for closure, it happened years after the contamination. This highlights the need for prompt investigations in that area to make sure that victims’ demands and safety in the health system are properly dealt with.

Criminal investigations were launched promptly after the contamination, although they went on for years. The first set of criminal proceedings started only 4 years after the episode. Moreover, an investigation conducted by a state-based institution may not have had the same impact as an inquiry conducted by an independent investigator for the victims in terms of closure. The length of criminal proceedings was though a great disadvantage and was criticised by the victims, academics and the media.<sup>171</sup> The ignorance of judges on HIV/AIDS and the irrelevance of witnesses’ reports were also subject of criticism, which showed that the criminal process was not wholly

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<sup>168</sup> O Beaud, above n10 at 47.

<sup>169</sup> Ibid.

<sup>170</sup> Ibid.

<sup>171</sup> C Got, ‘La justice malade des lois baclées’, *Libération*, 8 juillet 2002.

adapted to deal with this type of healthcare failure.<sup>172</sup> In civil proceedings, the release of documents was first refused by the DH, but documents were eventually released which may have provided the victims with an understanding of the decision-making process and possible failures which caused the contamination of blood patients. However, many documents were lost. There were suspicions that the documents were maliciously destroyed. Archer did not find evidence of this but he noted that ‘had an official Public Inquiry been established while recollections were fresh, the suspicions might have been addressed’.<sup>173</sup>

Thus, the criminal process failed in terms of ensuring healthcare safety and responding to victims’ demands but investigations conducted by JIs were crucial in terms of closure and transparency. This shows that there is a need to improve investigation systems which could have substantial means of investigations in this type of failure.

### 6.3.6 Compensation

None of the responses in France and England adequately met the victims’ need for compensation. I suggest that neither the criminal justice system nor civil proceedings are designed to provide sufficient compensation to victims of healthcare accidents, in particular mass disasters where compensation needs might be difficult to assess. The lack of other means of compensation should not be a reason for a more ready use of the criminal process or litigation in general in healthcare malpractice. I thus point out that compensation is crucial in this type of healthcare malpractice episode and I propose in the next chapter that no-fault compensation schemes could be an answer.

In both countries, victims of the contamination episode asked for financial compensation from the responsible health authorities. Criminal proceedings arising out of the blood episode in France provided the *parties civiles* with some compensation although this was not the main motivation of victims for using the criminal process.<sup>174</sup> In France, victims also lodged civil proceedings individually against blood centres. They received compensation as a result but this did not

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<sup>172</sup> E Favereau, J Pérignon, ‘Le procès du sang contaminé: 4e jour. Rien ne va plus à la cour de justice. Le président a tenté de faire taire les critiques. En vain’, *Libération*, 13 février 1999.

<sup>173</sup> Rt Hon Lord Archer of Sandwell QC, above n5 at 74.

<sup>174</sup> MA Hermitte, above n10 at 322.

respond to their need for retribution.<sup>175</sup> In both countries, compensation funds were also created to ensure that victims obtain compensation for the harm caused. It will be shown in this section that in France, victims were dissatisfied with the outcome of the first set of proceedings on compensation and in England, victims were dissatisfied with the amount of ex gratia payments made by the DH. Thus, neither process provided the victims with sufficient compensation.

*Parties civiles* in France were given compensation from the *Tribunal correctionnel* in the first set of criminal proceedings for being deceived by Garetta and Allain. Only those who had evidence that they had purchased FCs between 21 March 1985 and 1<sup>st</sup> October 1985 were compensated.<sup>176</sup> 100,000 Francs were offered to victims already contaminated before the 21 March 1985 and 300,000 Francs for other victims.<sup>177</sup> Victims were unhappy with the compensation they received as a result of the first set of proceedings in France as the compensation was limited to victims who had lodged complaints for *tromperie*. Victims claimed that compensation was too low to represent the ‘cost of life’.<sup>178</sup>

Two compensation funds were created in France in 1989 to compensate PWH victim of the contamination.<sup>179</sup> The funds provided 325,000 Francs to victims as long as they renounced to legal action.<sup>180</sup> Victims considered the compensation much too low and thus relied on legal proceedings including criminal proceedings to get compensation even though this was not their main motivation to use the criminal process.<sup>181</sup> In 1991, thanks to both media coverage on the scandal and legal proceedings, another compensation fund was created.<sup>182</sup> It was said to have responded to victims’ demands for compensation more appropriately.<sup>183</sup> It provided rapid payments to both PWH and blood recipients who had been contaminated with

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<sup>175</sup> Ibid 275-285.

<sup>176</sup> Ibid 392.

<sup>177</sup> Ibid.

<sup>178</sup> L Greilsamer, above n11 at 204-205; I was unable to find any information on the compensation awarded to victims in the second and third sets of proceedings. Thus, the claims made in this section are only based on the comparison of compensation given to victims in the first set of proceedings in France to ex gratia payments awarded to victims in England.

<sup>179</sup> MA Hermitte, above n10 at 322.

<sup>180</sup> Ibid.

<sup>181</sup> Ibid.

<sup>182</sup> Ibid 323-324; Loi du 31 décembre 1991 JO du 4 janvier 1992, 178.

<sup>183</sup> Ibid.



HIV as a result of the use of blood products.<sup>184</sup> The fund considered each victim individually and extended the compensation to family members who were harmed as a result.<sup>185</sup>

In England, financial compensation to PWH who had been victim of the HIV-contamination was not automatic. PWH had to campaign to obtain compensation and remained dissatisfied after they were awarded ex gratia payments because they claimed they were too low. From June 1987 in England, the Haemophilia Society started lobbying Members of the Parliament. HIV-infected PWH wrote letters to Members of the Parliament explaining the financial difficulties they were facing as a result of two medical disorders (HIV/AIDS and Haemophilia).<sup>186</sup> They obtained the support of around 200 Members of the Parliament. The Haemophilia Society had requested the DH that a special fund be established which would grant £90 to £100M to support infected PWH.

The Rt Hon Tony Newton, then Minister of Health responded to this demand by giving to the 1,200 infected Haemophilia patients £10M, which was much less than what they had asked for.<sup>187</sup> The funding was organised into a trust created by the Government in 1988, the MacFarlane Trust.<sup>188</sup> When the trust was created, a first payment of £20,000 was granted to each patient.<sup>189</sup> In December 1989, the Government made a further grant of £24M in the trust so that each Haemophilia patient who had been contaminated with FCs be awarded £20,000.<sup>190</sup> In 1992, these payments were extended to Haemophilia patients who had been contaminated as a result of blood transfusion or tissue transfer.<sup>191</sup> Further payments of £41,500 to £80,500 were made.<sup>192</sup> However, the Government underlined the fact that the grant was not to be viewed as financial compensation for the contamination, but as ex gratia payments, as they argued that health authorities had not admitted negligence. The payments were not thus based on the quantum of damages that would be

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<sup>184</sup> Ibid.

<sup>185</sup> MA Hermitte, above n10 at 329-330.

<sup>186</sup> J Carvel, 'The Day In Politics: Old lobbying virtues win victory for AIDS case', *The Guardian*, 17 November 1987; Mr Justice Horace Kever, above n3 at 939.

<sup>187</sup> Mr Justice Horace Kever, above n3 at 939.

<sup>188</sup> Rt Hon Lord Archer of Sandwell QC, above n5 at 76.

<sup>189</sup> Mr Justice Horace Kever, above n3 at 939.

<sup>190</sup> Ibid 939-940.

<sup>191</sup> Ibid.

<sup>192</sup> Ibid 940.

awarded as compensation in the courts.<sup>193</sup> Had claims been successfully pursued or fault admitted, holding health officials to account in court might well have resulted in higher compensation to victims.

The Archer Inquiry Report in 2009 advised that the DH provide further payments to the victims so that payments made in England would align to those made in Ireland.<sup>194</sup> On the 14 October 2010, a written ministerial statement of the DH by the Parliamentary Under Secretary of State Anne Milton, following a judicial review, stated that Archer's recommendation on aligning payments to victims on those made in the Republic of Ireland was not acceptable, emphasising that such measure would cost £3 billion.<sup>195</sup> However, it was argued in the House of Commons that the payments should be made, regardless of the cost: 'I fully appreciate that money is tight, but morality is absolute, not some relative concept that expands and contracts to suit circumstances. We cannot as a society be more moral in good times than in bad'.<sup>196</sup> Dr Philip Lee claimed that 'the present difficulties that our Government are dealing with are not a consideration. A big wrong occurred, and we need to deal with it irrespective of the timing'.<sup>197</sup>

Ex gratia payments were a way to financially support HIV-contaminated patients. However, ex gratia payments did not respond to the initial demand of patients who had requested £90 to £100M to be granted. Victims argued that the payments provided by the Macfarlane trust did not meet their needs and were way below those given in other countries (especially the Republic of Ireland).<sup>198</sup> In Ireland, there were grounds that the contamination with Hepatitis C was a result of acts and omissions by the state and blood transfusion services.<sup>199</sup> Patients were initially unsatisfied with payments made by the Government as a result of litigation but by 2001 civil cases were settled for €6.7M, which was much higher than in England.<sup>200</sup>

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<sup>193</sup> Rt Hon Lord Archer of Sandwell QC, above n5 at 76; Mr Justice Horace Krever, above n3 at 939.

<sup>194</sup> Rt Hon Lord Archer of Sandwell QC, above n5 at 108-109.

<sup>195</sup> Department of Health, Written Ministerial Statement, Support to those affected by contaminated blood, 14 October 2010.

<sup>196</sup> HC Deb, 14 October 2010, vol 516, col 538.

<sup>197</sup> HC Deb, 14 October 2010, vol 516, col 542.

<sup>198</sup> Rt Hon Lord Archer of Sandwell QC, above n5 at 85.

<sup>199</sup> AM Farrell, above n34 at 197.

<sup>200</sup> Ibid 195-199.

The criminal process did not provide compensation at the level of what compensation funds could have granted. However, victims in both countries were dissatisfied by the compensation they had received from compensation funds. Payments were too low and not quick enough. I will in the next chapter make a claim that compensation and moral support should be developed but I will argue that this cannot be achieved through the criminal law but rather through no-fault compensation schemes.

## 6.4 Conclusion

This chapter aimed to discuss the appropriateness and efficiency of the criminal process in solving healthcare disasters such as the HIV-contaminated blood episode in France and England. The analysis of criminal offences used in the criminal proceedings arising out of the blood episode in France revealed that neither intentional offences nor negligence offences satisfied the victims and others.

Intentional offences were not appropriate regarding the failure to take appropriate measures against the contamination on the part of doctors and health officials, as intent to cause death or harm was not proven on the part of the accused. Moreover, they demonstrated the use of the criminal process for political and retributive reasons. Negligence offences, in particular *non-assistance à personne en danger* seemed to have been the best approach as they applied in the context of a failure to act. However, it did not criminalise the fact that health officials had given priority to economic interest instead of healthcare safety, and had shown obvious disregard to the life of patients. The main issue regarding negligence offences ie *homicide involontaire*, *blessures involontaires* and *non-assistance à personne en danger* was that victims claimed that sentences were not strong enough to represent the tragedy they had been through. Perhaps GNM might have responded to this issue in England, although gross negligence would have to be proven and it seems unlikely that juries would have admitted gross negligence in that case. However, we must note that it is difficult to assess how juries would have looked at this particular case. I suggested that corporate offences or health and safety offences could have been a better response to the episode, as they would have provided with some retribution as well as ensured deterrence and compliance by health institutions to their duties to improve

healthcare safety. I will in Chapter 8 discuss further the benefits and limits of using corporate offences and health and safety offences against health institutions for malpractice.

Even though the criminal process in France held some doctors and officials to account, victims still felt that justice had not been done because a great number of people who, they argued, should have been held accountable, were not and this showed that the criminal process was used as an instrument to achieve retribution. It was argued that ‘the fact that Haemophilia groups were forced to make use of the media and the law to achieve their demand for accountability, however, points to ongoing problems within the French polity in ensuring that bureaucrats and politicians are held to account for adverse outcomes in policy-making’.<sup>201</sup>

Even though the criminal process and in particular the information collected and the analysis of the decision-making process by JIs provided with an explanation of what had happened to victims, it lacked an in-depth analysis of systems errors and recommendations to health authorities. The Archer Inquiry resulted in the making of recommendations to health authorities, although these were not fully followed. The analysis of the Archer Inquiry pointed out the need to develop public inquiries with great means of investigation and which would ensure that health institutions comply with the recommendations made in the inquiry. The criminal process and ex gratia payments did not respond to the victims’ demands for compensation. Victims were left dissatisfied in both countries. This pointed out the need to ensure prompt and sufficient compensation to victims in such healthcare malpractice episodes. In the next chapters, I will consider the question of whether and, if so, when the criminal process should be used to redress healthcare malpractice in general and whether it is the best response to healthcare malpractice, and I will suggest other alternatives which might address insufficiencies of the criminal process.

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<sup>201</sup> Ibid 113.

## 7. Criminalising Individual Health Professionals for Malpractice?

### 7.1 Introduction

Criminal prosecution does not achieve the objectives of an appropriate response to unintended harm to a patient; notably it is expensive, it does not reliably identify correctable faults in the system, does not necessarily reduce the likelihood of recurrence, and does not usually address the need for compensation.<sup>1</sup>

Drawing on the earlier comparison on the role of the criminal law in healthcare malpractice in France and England in general, as well as in the specific context of the HIV-contaminated blood episode, I argue in this chapter that the criminal law should have a restricted role in individual healthcare malpractice.

I will be looking at different views expressed by authors such as Merry and McCall Smith, Quick and Ashworth on the role of the criminal law in healthcare malpractice. Quick has noted that ‘we are living in an era of quite obscene over-criminalisation’.<sup>2</sup> He argues that the criminal law should only be used at last resort and only recklessness should give rise to criminal liability.<sup>3</sup> Hall suggests that ‘no one should be punished unless he has clearly acted immorally, i.e., voluntarily harmed someone, and unless a criminal sanction is both suitable and effective’.<sup>4</sup> On the other hand, Ashworth argues that certain types of negligent conduct are ‘sufficiently culpable’ to be subject to criminal liability.<sup>5</sup> He claims that ‘negligence may be an appropriate

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<sup>1</sup> Until 1997, the law in New Zealand resembled the law in France in that simple negligence was criminalised. As a result of the argument above, New Zealand moved away from criminal liability for simple negligence rejecting the use of manslaughter for ‘acts of mere carelessness’ and moving closer to the law in England where only high degrees of moral culpability may be criminalised; A Merry, ‘When are Errors a Crime?-Lessons from New Zealand’, in C Erin, S Ost (eds), *The Criminal Justice System and Health Care* (Oxford University Press 2007) 96.

<sup>2</sup> O Quick, ‘Medicine, mistakes and manslaughter: a criminal combination?’ (2010) 69(1)*Cambridge Law Journal* 186, 187.

<sup>3</sup> Ibid 203.

<sup>4</sup> J Hall, ‘Negligent Behaviour should be excluded from penal liability’ (1963) 63(4) *Columbia Law Review*, 636.

<sup>5</sup> A Ashworth, *Principles of Criminal Law* (6<sup>th</sup> edn, Oxford University Press 2009) 188.

standard where there are well-known risks of serious harm'.<sup>6</sup> It might be argued that since doctors work in an environment where the risk of serious harm is high, they should be treated more severely. To the contrary, it could be argued that because any mistake in the medical setting could have tragic consequences—whereas in other contexts the same level of negligence might not cause harm at all—doctors should have special treatment.<sup>7</sup> Archard claims that 'doctors are unfairly subjected to the risks of criminal prosecution not suffered by the members of other professions'.<sup>8</sup>

Here I further develop the argument that in the context of healthcare malpractice, only obvious disregard to the life and health of another should trigger the use of the criminal law. Merry and McCall Smith argue that errors 'do not involve moral culpability' and thus cannot be deterred, whereas violations demonstrate a level of deliberate departure from 'those practices appreciated by the individual as being required by regulation, or necessary or advisable to achieve an appropriate objective while maintaining the safety of people and equipment and the ongoing operation of a device or system'.<sup>9</sup> These can be deterred because they involved an element of choice.<sup>10</sup>

I will explore whether and to what extent French criminal law could be used as a model for change in England in the context of individual healthcare malpractice. As there is a lack of evidence that the criminal process effectively deters healthcare practitioners from committing negligence as shown for instance in the blood episode<sup>11</sup>, I argue that the wider use of the criminal law in the context of negligence should not be followed in England. However, some features of French criminal law and procedure as used in healthcare malpractice might be adopted and adapted for use in England and I set out where this is, and is not, the case.

My argument is divided into three parts. First, I propose that to criminalise healthcare malpractice, there should be proof of a certain level of moral culpability and that we

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<sup>6</sup> Ibid 188.

<sup>7</sup> D Archard, 'Criminalising Medical Negligence' in A Alghrani, S Ost and R Bennett (eds) *The Criminal Law and Bioethical Conflict: Walking The Tightrope* (Cambridge University Press 2012), 244-245.

<sup>8</sup> Ibid.

<sup>9</sup> A Merry, A McCall Smith, *Errors, Medicine and the Law* (Cambridge University Press 2001) 2.

<sup>10</sup> Ibid.

<sup>11</sup> See ch6 pt6.3.1, 178.

should not punish ‘simple’ negligence as is done in France. I suggest that only obvious disregard for the life or health of another should be punished in a criminal setting but this should include failure to rescue, and conduct that results in injury or death. Currently, the uncertainty of the gross negligence test in England gives a great decisional power to juries and may lead to inconsistency in the criminalisation of health professionals who commit malpractice.<sup>12</sup> Endorsing Quick’s view, I advocate the abandonment of the gross test and a return to recklessness.<sup>13</sup>

Second, I suggest that in the context of healthcare malpractice, gross negligence manslaughter (GNM) is difficult to apply. I argue that the criminalisation of healthcare malpractice in England leaves too great a scope for moral luck as only conduct resulting in death is criminalised whereas morally culpable conduct which results in injury is not. I examine the possibility to widen the offences of causing grievous bodily harm and wilful neglect to all cases of healthcare malpractice or adopt clearer offences proposed by the literature<sup>14</sup> and the Law Commission<sup>15</sup> to replace GNM, and I discuss the question of whether aspects of French substantive criminal law could be borrowed to solve the current problems we have with GNM.

Third, while I argue that criminal law should only be used as last resort as it is not necessarily an effective response to counteract healthcare malpractice, I demonstrate that selected aspects of the French criminal process could be used in other mechanisms to achieve transparency and safety in the healthcare context as well as to respond to victims’ demands for accountability, closure and compensation.<sup>16</sup>

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<sup>12</sup> See ch2, 54.

<sup>13</sup> See ch2, 52.

<sup>14</sup> O Quick, ‘Medical Killing: Need for a Specific Offence?’, in CMV Clarkson, S Cunningham, (eds), *Criminal Liability for Non-Aggressive Death* (Ashgate 2008) 161; O Quick, ‘Medical Manslaughter: The Rise (and Replacement) of a Contested Crime?’, in C Erin, S Ost (eds), *The Criminal Justice System and Health Care* (Oxford University Press 2007) 43; D Griffiths, A Sanders, ‘The Road to the Dock: Prosecution Decision-Making in Medical Manslaughter Cases’, in D Griffiths and A Sanders (eds.), *Medicine, Crime and Society* (Cambridge University Press Forthcoming 2012); M Kazarian, D Griffiths, M Brazier, ‘Criminal Responsibility for Medical Malpractice in France’ (2011) 27(4) *Journal of Professional Negligence* 188, 195.

<sup>15</sup> The Law Commission (Law Com No 237), *Legislating the Criminal Code: Involuntary Manslaughter*, Item 11 of the Sixth Programme of Law Reform: Criminal Law, 4 March 1996, 45, 54.

<sup>16</sup> I acknowledge that my argument could apply to other contexts of negligence outside the medical sphere but this chapter and the one that follows will only focus on the criminalisation of healthcare malpractice.

## **7.2 Accountability of Individual Healthcare Professionals for Malpractice**

Drawing on the arguments made so far in the thesis, I argue in this section that it is morally wrongful conduct that should be subject to criminal liability. The criminalisation of healthcare malpractice should not depend on the chance of death and the level of moral culpability required for the criminalisation of health professionals should neither be the French test of simple negligence nor gross negligence but the higher test of recklessness.

### **7.2.1 Accountability for Error – ‘Simple Negligence’**

The simple negligence test<sup>17</sup> should not be sufficient to establish criminal liability in the healthcare malpractice context. Merry and McCall Smith argue that ‘there is overwhelming evidence that in fact all doctors make slip/lapse errors at some time, including errors in drug administration’.<sup>18</sup> Thus, injecting the wrong drug could be seen as a ‘sort of mistake a reasonable practitioner might make’, whereas ‘leaving an anaesthetised patient unattended’ would not be the sort of mistake a reasonable practitioner would make.<sup>19</sup> Merry and McCall Smith argue that in the former case, the use of a punitive response could be counter-productive whereas in the latter, it might be necessary.<sup>20</sup> Thus, they suggest that only ‘violations’, actions which show deliberate risk taking, as opposed to mere errors, should be subject to legal proceedings whether criminal, civil or disciplinary.<sup>21</sup>

On this basis, the French model of criminalisation of simple negligence should not be followed. Only healthcare professionals who showed obvious disregard for the welfare of their patient(s) should be criminally liable. In other cases, healthcare professionals should be subject to civil liability where the error did not involve moral culpability but may have caused serious harm, and professional disciplinary proceedings when the doctor’s behaviour was contrary to reasonable standards of

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<sup>17</sup> See ch2, 52.

<sup>18</sup> A Merry, A McCall Smith, above n9 at 3.

<sup>19</sup> Ibid.

<sup>20</sup> Ibid.

<sup>21</sup> Ibid.



practice required by the General Medical Council (GMC) or showed that he was not fully trained or competent.

In both France and England, the doctor's conduct is usually evaluated according to what a reasonable doctor would have done.<sup>22</sup> According to Merry and McCall Smith, negligence is a 'disparity between the actual conduct of the actor and the standard of conduct expected'.<sup>23</sup> Merry states that 'doctors do not go to work with the intention of harming people. [...]It is simply bad for any doctor's own professional advancement, smooth professional life, reputation, and peace of mind to harm patients'.<sup>24</sup> Thus, in Merry's view, when healthcare professionals commit errors, they should not be subject to criminal liability unless they have shown disregard for their patients.

Ashworth however argues that as long as an 'individual had the capacity' and the duty to take 'reasonable precautions', and when the risk of serious harm was obvious, he should be considered negligent and this should give rise to criminal liability.<sup>25</sup> I argue on the other hand that criminal law should only be used to punish morally wrongful conduct which showed a subjective element—the disregard, regardless of capacity. As Merry and McCall Smith argue, a disregard would be easier to deter than an omission when an individual had the capacity to do otherwise and evidence of a subjective fault would be easier to prove.<sup>26</sup> Conduct should be considered criminal where a doctor has chosen to act in an unsafe way. As McCall Smith argues, a 'person may decide not to meet expected standards simply because he finds it onerous to do so. This is unacceptable, and is regarded quite appropriately as morally culpable conduct'.<sup>27</sup> An example of this was the delay in taking measures against blood contamination in France and England for monetary reasons.<sup>28</sup> Even though Ashworth makes an arguable case on the criminalisation of negligent conduct, his definition of what should be criminal leaves too much scope for

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<sup>22</sup> D Papanikolaou, 'La responsabilité pénale des membres d'une équipe médicale' (2004) 14 *Revue générale de droit médical*, 80.

<sup>23</sup> A Merry, A McCall Smith, above n9 at 133.

<sup>24</sup> A Merry, above n1 at 95.

<sup>25</sup> A Ashworth, above n5 at 186-187.

<sup>26</sup> A Merry, A McCall Smith, above n9 at 4-5.

<sup>27</sup> A McCall Smith, 'Criminal negligence and the incompetent doctor' (1993) 1(3) *Medical Law Review*, 345.

<sup>28</sup> See ch4.

interpretation and is close to the current circular test of gross negligence. It is however different from the French test of simple negligence which does not take into account the capacity element.<sup>29</sup>

If we are to criminalise doctors and health officials for malpractice, we should consider their level of intention and knowledge. The defendant's state of mind should be examined. Criminal liability should not only depend on the outcome of the conduct. The criminal law should have a role when a doctor was aware of a risk but was indifferent to it. McCall Smith indicates that 'the person who decides not to take a particular precaution, or who decides to omit to do something which he knows to be necessary to prevent harm to others, is negligent in a way which is also morally culpable. He has made an unacceptable choice, and is legitimately called to account for it'.<sup>30</sup> He adds, 'the actor should be aware of all the relevant implications of his action. If he feels, for example, that what he is doing imports no potential wrong to others, then the choice, from his perspective, does not prefer his own interests to that of another'.<sup>31</sup> Thus, only in the first case should the person be criminally liable.

When establishing a doctor's state of mind, surrounding circumstances need to be taken into account. For instance, we should take into account factors in relation to the organisation and quality of the service, supervision and the physical state of the doctor, in order to determine where his negligence originated from and whether his conduct was deliberate rather than negligent or grossly negligent.<sup>32</sup> Hall considers that 'one must always ask whether the actor knew he was creating an unwarranted, unreasonable risk'.<sup>33</sup> It would be unfair to prosecute a doctor whose conduct was the result of another healthcare professional's negligence or of a disorganisation of the service.<sup>34</sup> A junior doctor was charged with GNM because he had injected penicillin into the brain of the patient instead of intravenously but was acquitted, because he had been working 14 hours in the same day and 110 hours the week before.<sup>35</sup> The victim's widow declared that the doctor 'had paid the price for the long hours

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<sup>29</sup> See ch2, 52.

<sup>30</sup> A McCall Smith, above n27 at 344.

<sup>31</sup> Ibid 345.

<sup>32</sup> J Hall, above n4 at 637.

<sup>33</sup> Ibid 637.

<sup>34</sup> A McCall Smith, above n27 at 349.

<sup>35</sup> RE Ferner, 'Medication errors that have led to manslaughter charges' (2000) 321(7270) *British Medical Journal*, 1214.

demandé from untrained doctors’.<sup>36</sup> This is an example of a doctor’s negligence which resulted from failures in the quality of the system. In this case, surrounding elements were taken into account to acquit the defendant. Similarly, judges recognised that Drs Prentice and Sullman had made a mistake but claimed that because they were not trained and supervised properly, they were ‘far from being bad men’.<sup>37</sup> The Court of Appeal later decided that their conduct was not gross in all the circumstances. They would have remained convicted in France. Therefore, the simple test of negligence is not sufficient to establish culpability when in so many cases the error of one doctor might result from multiple external factors.

The level of doctors’ moral culpability needs to be determined with regard to their general conduct and surrounding factors. The level of awareness of doctors, health officials and ministers in the contaminated blood episode was a determinant factor in criminal proceedings in France. Investigations conducted by medical experts and involving witnesses are necessary to determine a doctor’s level of awareness and intention. This will be developed later in this chapter. Before that, given that I argue that to criminalise a negligent doctor, there should have been a certain level of blameworthy conduct that is more than mere error, it must be determined whether the test should be gross negligence or recklessness.

### **7.2.2 Gross Negligence vs Recklessness**

Since I have argued that contrary to France, England should only criminalise culpable conduct, and not simple errors, should the test be gross negligence or recklessness? In Chapter 2, I highlighted concerns about the test of gross negligence as circular and unclear.<sup>38</sup> Here, I argue that a better test is recklessness.

A violation is seen by Merry and McCall Smith as a disregard for the consequences of certain conduct.<sup>39</sup> In France, *faute délibérée* is found when someone has ‘broken a duty of care or precaution laid down by statute or regulation in a manifestly

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<sup>36</sup> Ibid.

<sup>37</sup> *R v Prentice* [1993] 3 WLR 927.

<sup>38</sup> See ch2, 54.

<sup>39</sup> A Merry, A McCall Smith, above n9 at 149.

deliberate manner’.<sup>40</sup> Violation and *faute délibérée* go further than recklessness in the sense that they are deliberate conduct and the French definition provides that a duty of care has to be broken. Here I will not argue that in the context of healthcare malpractice, all these conditions should be fulfilled to criminalise doctors. However, I will argue that there must be proof of subjective recklessness. McCall Smith indicates that the requirement for recklessness is the knowledge of a risk.<sup>41</sup> Gross negligence is described as the ‘failure to take steps which fall into the category of elementary precautions’, or the ‘failure to take certain steps in circumstances in which the consequences of a mishap would be particularly serious’.<sup>42</sup> However, there is only a thin line between recklessness and gross negligence and it was argued that the definition of gross negligence in English criminal law remains unsatisfactory.<sup>43</sup> Quick claims that ‘the current test for liability (gross negligence) is unclear, unprincipled, often unfair and ought to be abolished’.<sup>44</sup> He claims that ‘committing to a form of subjective reckless liability would likely lead to a decrease in individual prosecutions’.<sup>45</sup> Even though prosecutions against doctors remain very few as I explained in Chapter 2<sup>46</sup>, I suggest later in this chapter that the very fact of a criminal investigation could have potentially bad effects on a doctor and on the delivery of healthcare, so a decrease in prosecutions could be an advantage.

Later in this chapter, I shall re-enforce my argument that the offence of GNM is too broad and leaves too great a scope for prosecutorial and jury discretion. McCall Smith claims, ‘...the only respect in which gross negligence should be treated as being more culpable than ordinary negligence is if it demonstrates an awareness on the part of the accused of the risk to which he is subjecting others’.<sup>47</sup> I acknowledge however that if reform does not happen in that area, the practice requirement of the Crown Prosecution Service (CPS) for subjective fault could be a way to mitigate the

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<sup>40</sup> Art 223-1 CP.

<sup>41</sup> A McCall Smith, above n27 at 336-349.

<sup>42</sup> Ibid 343.

<sup>43</sup> O Quick, ‘Medical Manslaughter: The Rise (and Replacement) of a Contested Crime?’, above n14 at 43; V Tadros, ‘The Limits of Manslaughter’ in CMV Clarkson, SR Cunningham (eds), *Criminal Liability for Non-Aggressive Death* (Ashgate 2008) 49.

<sup>44</sup> O Quick, above n2 at 1.

<sup>45</sup> O Quick, ‘Medical Manslaughter: The Rise (and Replacement) of a Contested Crime?’, above n14 at 46.

<sup>46</sup> See ch2, 37.

<sup>47</sup> A McCall Smith, above n27 at 344.

uncertain effect of gross negligence on doctors (although I highlight the risks of unfairness in such an approach).

A better test for the criminalisation of healthcare malpractice is recklessness. However, reckless conduct might have different consequences in different contexts, ie the same conduct might result in death or injury, depending on luck.<sup>48</sup> How should the criminal law deal with moral luck issues in the healthcare context?

### 7.2.3 Moral Luck

In France, conduct resulting in bodily injury may be subject to criminal liability. In England, healthcare professionals who cause non-fatal injury to patients, regardless of how reckless they may be, are not currently subject to criminal liability except in the context of wilful neglect of mental health patients or mentally incapacitated patients.<sup>49</sup> In theory, a charge of inflicting grievous bodily harm could apply to cases of healthcare malpractice resulting in injury but it has not been used as yet in that area.<sup>50</sup> Whether a health professional causes death or only injury to his patient is often a matter of luck, as the same act could have different effects on a human body.<sup>51</sup> Moral luck and thus causation issues are even more complex in medical cases than in many other cases of negligence due to the nature of the profession and the complexity of events leading to the injury or death as many patients victim of healthcare malpractice are already terribly ill before the doctor's intervention.<sup>52</sup>

The consequences of a severe injury can be as tragic as death for the victim or his family. As an example, Jamie Merrett had been severely injured in a car accident, and needed intensive care and a life support machine to live, but his cognitive function was unimpaired.<sup>53</sup> A camera installed by his bed caught a nurse switching off his ventilator by mistake and failing to resuscitate him as she did not know how

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<sup>48</sup> RA Duff, 'Whose Luck Is It Anyway?', in CMV Clarkson, S Cunningham (eds), *Criminal Liability for Non-Aggressive Death* (Ashgate 2008) 61.

<sup>49</sup> See ch2, 44.

<sup>50</sup> See ch2, 43.

<sup>51</sup> A McCall Smith, above n27 at 348.

<sup>52</sup> D Griffiths, A Sanders, above n14 at 189.

<sup>53</sup> J Hope, P Bentley, 'Pictured: The moment paralysed man was left brain-damaged after bungling nurse 'turned off his life-support machine'', *Daily Mail*, 26 October 2010.

to use the resuscitation equipment. Mr Merrett was left with severe brain damage.<sup>54</sup> This error removed any quality of life Mr Merrett could have enjoyed after his accident. In previous chapters, I have also mentioned cases where a doctor's negligence resulted in life-threatening diseases or conditions, as was the case in the HIV-contaminated blood episode for many victims. Currently, English criminal law is unfair to both victims and doctors. A victim may be left with severe injury short of death no matter how reckless the behaviour of a doctor (A) was and would not be able to benefit from the use of the criminal process against him. In contrast, another doctor (B) whose negligence has caused the death of a patient may be subject to the criminal process even though his level of culpability did not reach A's level of culpability.

Thus, if we are to criminalise health professionals for reckless conduct, this gap in English criminal law needs to be addressed as it leaves too much scope for moral luck. Quick calls this gap an unsatisfactory "all or nothing" scenario, often hinging on moral luck and prosecutorial (and expert witness) performance'.<sup>55</sup> This could be done without general law reform. In the next section, I will assess whether existing criminal offences could 'cure' this problem or if new offences should be created. I will consider offences proposed in the literature and look at what French offences can teach us to rationalise the criminalisation of conduct resulting in death or injury in the healthcare setting.

#### **7.2.4 Criminal Offences**

##### **Reforming/Replacing GNM?**

As I have argued above, a preferable test to criminalise 'bad' conduct is recklessness. In Chapter 2, I raised concerns about the uncertainty of the offence of GNM in English criminal law. A conviction for GNM is left in the hands of the jury, who will determine whether a doctor's conduct is criminal. Because the test is unclear, it makes it difficult for juries to interpret it and judge what should be criminal, in

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<sup>54</sup> Ibid.

<sup>55</sup> O Quick, above n2 at 186.

particular in healthcare cases which are often complex. As indicated above, Quick has highlighted the need to address the ‘vagueness’ of this offence.<sup>56</sup> He argues that we should abolish the offence of GNM as it ‘is too broad for prosecutorial judgment to be consistently applied, and this translates into particular harshness for those operating in error-ridden activities who are exposed to risk of prosecution by virtue of their socially vital work, and are often at the mercy of moral luck’.<sup>57</sup> Tadros notes that ‘the offence of manslaughter is very broad indeed. It includes defendants who are very seriously culpable, but also defendants who, in one way or another, lack a high degree of blameworthiness for killing’.<sup>58</sup>

The Law Commission has discussed the adoption of new offences to replace GNM and address problems arising from its application.<sup>59</sup> It proposed the use of the offence of ‘killing by gross carelessness’ which requires that:

- (1) a person by his or her conduct causes the death of another;
  - (2) a risk that his or her conduct will cause death or serious injury would be obvious to a reasonable person in his or her position;
  - (3) he or she is capable of appreciating that risk at the material time;
- And
- (4) *either*
    - (a) his or her conduct falls far below what can reasonably be expected of him or her in the circumstances, *or*
    - (b) he or she intends by his or her conduct to cause some injury, or is aware of, and unreasonably takes, the risk that it may do so, *and* the conduct causing (or intended to cause) the injury constitutes an offence.<sup>60</sup>

As Quick argues, the creation of the offence ‘killing by gross carelessness’ would be an improvement in theory but not in practice because it would not solve current problems we have with GNM.<sup>61</sup> Quick argues that ‘the eschewal of the term

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<sup>56</sup> O Quick, ‘Medical Killing: Need for a Specific Offence?’, above n14 at 161.

<sup>57</sup> O Quick, ‘Medical Manslaughter: The Rise (and Replacement) of a Contested Crime?’, above n14 at 38.

<sup>58</sup> V Tadros, above n43 at 42.

<sup>59</sup> The Law Commission, above n15 at 45, 54.

<sup>60</sup> Ibid.

<sup>61</sup> O Quick, ‘Medical Killing: Need for a Specific Offence?’, above n14 at 161.

manslaughter is to be welcomed, as is the reference to capacity'.<sup>62</sup> However, the proposed offence would not eliminate the problem of circularity of GNM and is close to Ashworth's definition of criminal negligence.<sup>63</sup> Prosecutors and experts would have to determine 'conduct which falls far below what can reasonably be expected in the circumstances'.<sup>64</sup> This offence does not seem to address GNM issues and it retains an element of circularity because it does not precisely indicate what should be considered as being conduct which fell seriously and significantly below what could reasonably be expected from the professional. As for GNM, the jury will have to decide on what should be criminal and this again may lead to inconsistencies in convictions. Quick argues that the reformulation has a broader scope than the definition of GNM, which is likely to result in an increase in criminal prosecutions but he acknowledges that this might not 'make much a difference in practice'.<sup>65</sup> I suggest that the use of 'killing by gross carelessness' will not have a much different outcome than that of GNM because its definition is just as circular as GNM's definition. The definition does not clearly state what 'gross carelessness' is.

The offence of 'reckless killing' proposed by the Law Commission could achieve this and address issues related to the application of GNM, as it requires that 'reckless killing would be committed if: (1) a person by his or her conduct causes the death of another; (2) he or she is aware that his or her conduct will cause death or serious injury; (3) it is unreasonable for him or her to take that risk, having regard to the circumstances as he or she believes them to be'.<sup>66</sup> It contains the element of awareness and the choice of taking the risk and could reduce the scope for uncertainties and circularity. However, the term 'killing', which might suggest an element of intention in popular understanding, could be replaced by the less pejorative term 'causing death'.

Similarly, a definition proposed by Tadros of a form of reckless manslaughter could be an option. It would require that (a) the action was of a kind that might carry risks with it according to the beliefs of the individual; and either (bi) given those beliefs

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<sup>62</sup> O Quick, 'Medical Manslaughter: The Rise (and Replacement) of a Contested Crime?', above n14 at 42.

<sup>63</sup> Ibid 43.

<sup>64</sup> Ibid.

<sup>65</sup> Ibid.

<sup>66</sup> The Law Commission, above n15 at 45.



the agent failed to fulfil his duty of investigating the risks; or (bii) the agent wilfully blinded himself to the existence of the risks'.<sup>67</sup> This definition is close to Merry and McCall Smith's definition of a 'violation' and could thus address issues arising from the gross negligence test in the healthcare malpractice context.

### **Conduct Resulting in Injury Short of Death**

Earlier, I raised concerns about the gap in English criminal law in the context of negligence, whereby it seems that healthcare professionals causing serious harm cannot at present be subject to criminal proceedings.<sup>68</sup> Crucial factors in determining criminal responsibility should not only depend on the outcome of the conduct but also on the level of culpability involved. Thus, criminal liability for conduct resulting in injury should not depend on moral luck.

Several French offences could inform criminal liability for conduct resulting in injury in England.<sup>69</sup> Two offences could be used here as models to criminalise conduct resulting in injury short of death. A form of the French *blessures involontaires* could be an appropriate option. *Non-assistance à personne en danger* could also be used but a general duty to rescue would have to be recognised in England. I suggest in the next chapter that this should apply to managers or regulators who failed in their obligations and may thus be the principal contributor to failures that result in harm.

Griffiths and Sanders have proposed an offence of 'medical neglect endangering life'.<sup>70</sup> This new offence would permit the criminalisation of conduct resulting in injury short of death and address omissions, which is to be welcomed. However, I have reservations about whether a new offence specific to healthcare should be created.<sup>71</sup> Creating an offence specific to healthcare could send out a message that society judged that there was a particular problem with healthcare malpractice that

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<sup>67</sup> V Tadros, 'Recklessness and the Duty to Take Care', in S Shute and AP Simester (eds), *Criminal Law Theory: Doctrines of the General Part* (Oxford University Press 2002) 227, 255.

<sup>68</sup> See Ch2, 43.

<sup>69</sup> Ibid.

<sup>70</sup> D Griffiths, A Sanders, above n14.

<sup>71</sup> O Quick, above n2 at 187.

the criminal law should deal with. This could thus lead to an increase in prosecutions against doctors because prosecutors and juries might be less reluctant to prosecute and convict for lesser offences than manslaughter.

Existing health and safety offences might also be used against individual healthcare professionals under section 7 of the Health and Safety at Work Act 1974 (HSWA 1974) which provides that an employee at work should ‘take reasonable care for the health and safety of himself and of other persons who may be affected by his acts or omissions at work’.<sup>72</sup> These offences have the potential to embrace different types of healthcare malpractice cases but current Health and Safety Executive (HSE) policy excludes cases resulting from bad clinical judgment or quality of care and do not require recklessness and it has not been used against individuals.<sup>73</sup> The regulatory nature of offences contained in the HSWA 1974, which are specially designed to preserve health and safety, could achieve some of the functions of the criminal law ie deterrence and prevention and ensure healthcare safety. Nevertheless, they might become ineffective in terms of responding to victims’ demands for retribution as the HSWA 1974 is a scheme of regulation, close to *délits*. Yet, it was found in the blood episode that victims and their families found that the use of *délits* was insufficient in providing retribution.

To criminalise reckless conduct resulting in injury in healthcare malpractice, there is however no need for a new offence to be created as reckless malpractice causing injury would be covered by section 20 of the Offences Against the Person Act 1861 (OAPA 1861) ‘grievous bodily harm’.<sup>74</sup> Recklessness must be proven as to some physical harm only and there is no need to prove recklessness as to grievous bodily harm.<sup>75</sup> Moreover, section 20 does not require proof of an assault.<sup>76</sup> I therefore support the argument made elsewhere by Kazarian, Brazier and Griffiths that section 20 of the OAPA 1861 should be used in healthcare malpractice cases.<sup>77</sup> Grave cases of healthcare malpractice that meet the criteria I have set for culpable and reckless

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<sup>72</sup> HSWA 1974 s 7.

<sup>73</sup> See <<http://www.hse.gov.uk/healthservices/arrangements.htm>>.

<sup>74</sup> Offences Against the Person Act 1861 (OAPA 1861) s 20.

<sup>75</sup> *Mowatt* [1968] 1 QB 421.

<sup>76</sup> *Wilson, Jenkins* [1984] AC 242; *Savage and Parmenter* [1992] 1 AC 699; *Mandair* [1995] 1 AC 208; *Ireland and Burstow* [1998] AC 147; A Ashworth, above n5 at 311.

<sup>77</sup> M Kazarian, D Griffiths, M Brazier, above n14.

conduct would be covered by this. For instance, the Jamie Merrett case (see above) would be covered by section 20. This implies that no change in the law will be needed but prosecutorial policy will have to change to admit prosecutions against practitioners who recklessly caused injury.

It will be discussed in the next chapter whether England, following the French model of *non-assistance à personne en danger*, should recognise a general duty to rescue. I will particularly emphasise the fact that in many cases of healthcare malpractice, people who we could and should hold to account do not always owe a duty of care to patients under the common law. The offence of ‘wilful neglect’ permits the criminalisation of those who neglect mental health patients and patients who lack mental capacity.<sup>78</sup> It has been suggested that the offence of ‘wilful neglect’ be broadened to all patients receiving care.<sup>79</sup> This could apply to healthcare professionals directly providing care but is unlikely to work against health officials or regulators who recklessly failed to ensure safety.

### **7.3 The Usefulness of Criminal Procedure in Criminalising Individual Health Professionals for Malpractice**

In Chapter 3, I have shown that the French inquisitorial procedure allowed more scope for the criminalisation of doctors and health officials.<sup>80</sup> In particular, the presence of a *juge d’instruction* (JI) and the possibility for victims to launch prosecutions seemed to explain the greater number of prosecutions in France. The analysis of the contaminated blood episode and in particular the evidence from the interview with Bertella-Geffroy confirmed the claims made in Chapter 3.<sup>81</sup> From what I have found in the blood episode, healthcare malpractice victims’ main motivation in using the criminal process was to benefit from investigations

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<sup>78</sup> See Ch2, 44.

<sup>79</sup> M Kazarian, D Griffiths, M Brazier, above n14; N Allen, ‘Psychiatric Care and Criminal Prosecution’ in D Griffiths, A Sanders (eds), *Medicine, Crime and Society* (Cambridge University Press 2013) 165; A Alghrani et al., ‘Health care scandals in the NHS: Crime and punishment’ (2011) 37(4) *Journal of Medical Ethics* 230, 231.

<sup>80</sup> See ch3 pt3.2, 64.

<sup>81</sup> See ch3 pt3.3, 66.

conducted by a JI, join civil claims for compensation and ensure accountability and deterrence.<sup>82</sup>

In this section, I seek to address the question of whether lessons can be learned from what the French process allows in terms of transparency and compensation without necessarily resorting to the criminal law. Following on the analysis of the effectiveness of the criminal process in responding to the blood episode in France, I highlight the importance of in-depth investigations conducted by an independent body with wide investigative powers, the need to involve victims in procedures against practitioners and the need to compensate victims appropriately.<sup>83</sup> I argue that the criminal process is not a solution to healthcare malpractice when the conduct was only negligent but some of the features of French criminal procedure could be used in considering alternatives to the criminal process in the context of healthcare malpractice.

### **7.3.1 Victims' Voices**

I have previously demonstrated that victims in France play a larger role in the criminal process than in England.<sup>84</sup> The question that arises here is how much participation in and access to criminal proceedings victims of healthcare malpractice should be permitted. I will show in this section that some advantages of the French criminal process for victims of healthcare malpractice could inform other responses to healthcare malpractice.

In Chapter 3, I pointed out the advantages of joining civil claims for compensation for victims of healthcare malpractice in criminal proceedings. Here, I argue that although it is not feasible for the English process to adopt a system of civil claims for compensation attached to criminal prosecutions and unlikely to happen given the drive to reduce legal aid for victims of clinical negligence<sup>85</sup>, the involvement of victims is crucial in proceedings for healthcare malpractice to ensure closure and transparency.

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<sup>82</sup> See ch5 pt5.3.1, 140.

<sup>83</sup> See ch6 pt6.3.6, 192.

<sup>84</sup> See ch3 pt3.3, 66.

<sup>85</sup> Ibid.

The right of victims to join civil claims for compensation in criminal courts has both positive and negative aspects. Victims can highlight a serious case of healthcare malpractice to investigating judges and prosecutors that they had not considered, or they might start proceedings against a case which is not serious enough to be dealt with in a criminal court but at the end, neither victims nor doctors would be satisfied, as shown in the blood episode in France.<sup>86</sup> Guigue pointed out that victims of healthcare malpractice in France decide to prosecute doctors or health officials for retributive purposes only<sup>87</sup>, partly shown in the blood episode in France. The need for retribution is understandable and the criminal law is designed to achieve this aim. However, the right of victims to join civil claims for compensation to criminal complaint must not become a way to achieve retribution even if the doctor's negligence did not meet the criminal threshold of recklessness. The consequences of a criminal complaint with or without claim for civil compensation can be heavy for a healthcare professional in terms of media coverage and publicity, even where there was no ground for criminal liability.<sup>88</sup> If England followed the French model, the number of criminal prosecutions against doctors might increase dependent on what substantive offences exist. And there is a risk that victims may end up frustrated by the outcome of criminal proceedings which could lead to lower sentences than they had wished or no conviction at all, as was the case in the blood episode in France in most proceedings. However, it must be noted that the role of prosecutors and judges is to make sure that only culpable conduct should be dealt with by the criminal law and this should reduce the downside of the effect of *constitution de parties civiles*.

Civil claims for compensation also aim to obtain compensation for the harm caused. But is criminal law and more generally litigation designed to provide sufficient and fast compensation to victims of healthcare malpractice? As seen in the blood episode, the compensation given to victims at the end of the first set of proceedings was limited and occurred years after the first complaints. I will argue later that there are other mechanisms that could provide victims with quicker and greater compensation than the criminal process.<sup>89</sup> The no-fault compensation scheme created in France in

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<sup>86</sup> J Guigue, 'Les inconvénients de la pénalisation du droit de la santé' (2008) *Revue de droit sanitaire et social* 36.

<sup>87</sup> Ibid.

<sup>88</sup> Ibid.

<sup>89</sup> See pt7.5.

2002 is one example. I discuss the efficiency of the scheme later in this chapter.<sup>90</sup> On the other hand, the analysis of the French criminal process demonstrates the importance of providing the victims closure and understanding of what went wrong as well as financial compensation for the harm caused. I propose later that these aims can be achieved using alternative proceedings.

### 7.3.2 Investigations

A good understanding of the decision-making process and possible failure seems to be a pre-requisite to good healthcare practice.<sup>91</sup> Criminal investigations might help in understanding the healthcare decision-making process, but the information collected will need to be publicised and analysed so as to understand the causes of failure, look for a solution and fulfil the need for deterrence and closure.<sup>92</sup> In previous chapters, I have established that investigations conducted by a JI in the healthcare context in France provided a great deal of information for the justice system. JIs have substantial coercive powers of investigation and easy access to documents (thanks to *commissions rogatoires*<sup>93</sup>) and often rely on experts in healthcare malpractice cases.<sup>94</sup> Van Caenegem argues that ‘a judicial figure, closely engaged with the investigation, will be able to exercise effective control over the conduct of the investigation by the police’.<sup>95</sup> Nevertheless, in neither country are investigative files sent to health institutions to ensure that the event does not happen again in the future.

It must be noted however that in England, coroners<sup>96</sup> may give recommendations to the ‘person or authority who may have the power’ to ensure that such fatal event does not occur again.<sup>97</sup> The coronial jurisdiction that sits outside but alongside the

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<sup>90</sup> See pt7.5.4.

<sup>91</sup> A Edwards, G Elwyn, Chapter 1, in A Edwards, G Elwyn (eds), *Shared decision-making in health care : Achieving evidence-based patient choice* (2<sup>nd</sup> edn, Oxford University Press 2009) 4.

<sup>92</sup> See Ch6 pt6.3.5, 185.

<sup>93</sup> When the JI cannot conduct certain acts of investigation himself, he may give ‘*commission rogatoire*’ to police officers who will conduct these acts; art 81 al 4 CPP; see ch3 pt3.4.1, 71.

<sup>94</sup> See ch3 pt3.4.2, 76.

<sup>95</sup> W Van Caenegem, *Advantages and Disadvantages of the Adversarial System in Criminal Proceedings*, Law Reform Commission of Western Australia, Review of the Criminal and Civil Justice System in Western Australia, Vol. (1999) 73.

<sup>96</sup> See ch3 pt3.4.1, 71.

<sup>97</sup> Coroners Rules 1984 SI 1984 No 552, Rule 43; See AK Fletcher, ‘Coroners’ Rule 43 reports’ (2011) 17(6) *Clinical Risk* 217-219.

criminal justice system may play an increasingly important role in investigating deaths in healthcare settings and the need for thorough investigations might be addressed by coroners in England, but only if the victim dies. This is one of the only features of English criminal procedure which proves useful in the context of healthcare malpractice.

Investigative files could be sent to health institutions in both countries but as criminal investigations usually go on for many years, the evaluation of the case by health institutions and addressing the problem would occur much too late to ensure that issues are solved and health and safety are protected. Other investigation processes could actually respond to this problem more effectively.<sup>98</sup>

In Chapters 3 and 6, I have demonstrated that investigations may help to determine the causal link between a possible error or negligence and the harm caused by analysing the decision-making process in health institutions and the conduct of health professionals and health officials.<sup>99</sup> Thus, they could contribute to identifying allegedly responsible people. This identification may also play a role in learning from errors and preventing them from occurring again in the future.<sup>100</sup> However, criminal investigations are limited in the sense that they may omit certain factors or persons that also contributed to the harm caused. In the contaminated blood episode, JIs did not take into account the chain of events that led to the contamination and only pointed out individual failures, resulting in criminal proceedings involving more than 30 people.<sup>101</sup>

Merry and McCall Smith argue that proceedings for individual liability ‘often fail to identify systemic deficiencies which predispose to error, or fail to protect the patient against the consequences of inevitable error’.<sup>102</sup> Nevertheless, in the blood episode in France, JIs identified individuals who had acted against medical ethics, considering financial profit rather than healthcare safety. Thus, the role of JIs is crucial when it comes to detangling the decision-making process to identify individual reckless

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<sup>98</sup> See pt7.5.

<sup>99</sup> See ch3 pt3.4.1, 71; ch6 pt6.3.5, 185.

<sup>100</sup> A Merry, A McCall Smith, above n9 at 164.

<sup>101</sup> Ch6 pt6.3.5, 185.

<sup>102</sup> A Merry, A McCall Smith, above n9 at 2.

behaviour and pick out particular individuals who went beyond error as was the case in the blood episode in France.<sup>103</sup> Investigations conducted by JIs in France allow more disclosure than investigations conducted by the police in England.<sup>104</sup> The hearing of the defendant by the JI might also provide information on his level of moral culpability.

The inquisitorial process seems to provide more transparency than the adversarial process and its features should inform alternatives to the criminal process as I suggest later in the chapter. However, we must be careful that criminal investigations do not result in doctors being defensive, which would be counterproductive, although there is not clear evidence that criminal liability provokes defensive medicine.<sup>105</sup> It was argued that investigations in French criminal procedure are counter-productive as they put doctors in a position of ‘delinquent’ and refrain from finding the ‘truth’ as they render the accused defensive and arrogant.<sup>106</sup>

Moreover, in both France and England, criminal investigations of healthcare malpractice are conducted by non-medical specialists. This raises the question of whether investigators, whether judge or police, are in a position to consider whether a doctor or health official acted in a reasonable way. This has even more impact in French criminal procedure, where the JI can influence criminal proceedings by suggesting charges to the courts. This may be addressed by the role of medical experts in the investigations. Experts are essential when it comes to determining the level of negligence of doctors because they are scientists and healthcare professionals so they have the necessary qualifications to judge whether a conduct fell below what is expected of a reasonable doctor.<sup>107</sup> For instance, in Dr Adomako’s case, an expert claimed that the treatment given by Adomako to his patient was ‘abysmal’ and this helped in holding him liable for gross negligence.<sup>108</sup> However, it was argued in a *Sénat* conference on the *Loi Fauchon* in France in 2006 that experts in criminal

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<sup>103</sup> See ch6 pt6.3.5, 185.

<sup>104</sup> See ch3 pt3.4.1, 71.

<sup>105</sup> M Brazier, N Allen, ‘Criminalizing Medical Malpractice’, in C Erin, S Ost (eds) *The Criminal Justice System and Health Care* (Oxford University Press 2007) 24-25.

<sup>106</sup> Sénat, Les délits non intentionnels-La Loi Fauchon: 5 ans après-Actes du colloque, 1er mars 2006, Palais du Luxembourg 58.

<sup>107</sup> O Quick, ‘Medical Manslaughter: The Rise (and Replacement) of a Contested Crime?’, above n14 at 39.

<sup>108</sup> [1993] 4 All ER 935 at 952.



proceedings are often less specialised than the actual accused.<sup>109</sup> It was also pointed out that ‘the fact that expert evidence appears to effectively determine, as opposed to merely inform, what is supposedly a legal term of art, is inappropriate’.<sup>110</sup> The partiality of experts and their influence on the jury in the English adversarial procedure may be particularly detrimental to the need for unbiased investigations in healthcare malpractice cases.

Thus, perhaps, healthcare malpractice cases should be investigated by a body which has as much powers and means of investigation as JIs in France but which would be distinct from the criminal justice system. The shortcoming of investigations conducted by a single person is that it may take decades before a conclusion is reached on the case, especially when the investigator has to deal with complex cases such as healthcare malpractice cases, which are difficult in terms of establishing causation.<sup>111</sup> Investigations conducted in healthcare malpractice cases need to occur promptly in order to be effective. Therefore, JIs do not seem to be the best answer to ensure transparency and accountability in healthcare but some of what coroners do might be beneficial in healthcare malpractice cases. I suggest later that investigative processes might be the answer.<sup>112</sup>

### 7.3.3 Prosecution Policy

The role of the criminal law is to ensure that a wrong is punished because it affected social order.<sup>113</sup> Clarkson argues that ‘whether dangerous conduct is criminalised generally depends on balancing the seriousness of the possible harm and the likelihood of its occurrence against the social value of the conduct’.<sup>114</sup> In both France and England, public prosecution services are in charge of protecting the interest of the society.<sup>115</sup> Prosecutors would consider not only the likelihood of the conviction

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<sup>109</sup> Sénat, above n106 at 58.

<sup>110</sup> O Quick, ‘Medical Manslaughter: The Rise (and Replacement) of a Contested Crime?’, above n14 at 39.

<sup>111</sup> I Jamin, ‘La responsabilité pénale en milieu de soins: une préoccupation réelle, une menace relative?’ (2009) *Actualité Juridique Pénal* 340.

<sup>112</sup> See pt7.5.

<sup>113</sup> A Ashworth, above n5 at 2.

<sup>114</sup> CMV Clarkson, ‘General Endangerment Offences: The Way Forward?’, (2005) 32 *University of Western Australian Law Review* 131, 141-142.

<sup>115</sup> See ch3 pt3.5, 82.

but also whether a criminal prosecution in this case would advance the public interest<sup>116</sup>.

Does healthcare malpractice affect social interest so as to justify the use of criminal offences? I argue that a doctor's conduct will affect the interest of society as long as it was morally wrong and thus should be punished. As the Code for Crown Prosecutors quotes, prosecutions should occur 'wherever it appears that the offence or the circumstances of its commission is or are of such a character that a prosecution in respect thereof is required in the public interest'.<sup>117</sup>

However, the issue here is how much discretion to give to prosecutors in determining whether the conduct is morally wrong. The same concern about investigators can be made about prosecutors and judges. How can they determine that a doctor's conduct was negligent without medical knowledge even though they have the assistance of experts? The issue is even greater when proceedings involve a jury (in England), who are lay people with no legal or medical knowledge, and are supposed to establish whether if the doctor's act amounted to gross negligence.<sup>118</sup>

Offences (including GNM) used against allegedly negligent doctors must be clearly defined, so that prosecutors, judges or juries do not have too much discretion and courts decisions are consistent.<sup>119</sup> Quick highlighted that '[...] prosecutors work within this climate of increased suspicion of professionals which is likely to impact on the 'frames' they adopt in exercising their discretion'.<sup>120</sup> He also indicates that 'this is more probable given the public pressure associated with cases involving fatalities, coupled with the fact that the very definition of this offence depends on the use of discretion by prosecutors'.<sup>121</sup> However, it must be acknowledged that the role of experts instructed by prosecutors could give them too much power.

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<sup>116</sup> Ibid.

<sup>117</sup> Code for Crown Prosecutors 2010, 10.

<sup>118</sup> B Fitzpatrick, 'Court of Appeal: Gross Negligence Manslaughter: Compatibility with European Convention on Human Right, Article 7' (2005) 69(2) *Journal of Criminal Law* 104.

<sup>119</sup> CMV Clarkson, above n114 at 137.

<sup>120</sup> O Quick, 'Medical Manslaughter: The Rise (and Replacement) of a Contested Crime?', above n14 at 37.

<sup>121</sup> Ibid.

Thus, as argued above, conduct which affects the interest of society must be reckless conduct because the current gross negligence test leads to inconsistencies in the prosecution of healthcare practitioners. Moreover, even conduct which did not result in death but is morally blameworthy should be prosecuted for the sake of public interest and to encourage safer healthcare practice. Thus, as I have argued, reckless conduct resulting in harm in the healthcare context must be punished. If reform does not occur and the gross negligence test is still used to prosecute doctors, CPS policy on the requirement of a subjective fault could counteract the uncertainty of the gross test. However, this approach might lead to unfairness in the prosecution of healthcare cases as it could depend on opposing expert evidence as shown in Chapter 3.<sup>122</sup>

### 7.3.4 Jury

I have explained in Chapter 3 that in France, all negligence offences applicable in the healthcare malpractice context are *délits* and are dealt with in the *tribunal correctionnel*, which does not involve a jury. Currently in England, juries decide whether a doctor's conduct amounted to gross negligence and thus whether it is criminal.

I do not argue for the abolition of juries but I demonstrate that given the current ambiguous definition of gross negligence, juries constituted of lay people, could have difficulty understanding the standard of care expected from doctors.<sup>123</sup> If the case goes to trial, the facts will be discussed by opposing experts, which could make the jury's task even more difficult.<sup>124</sup> This may result in arbitrary judgments. As Tadros argues, juries 'lack knowledge of the relevant standards in other contexts to do the comparison in the appropriate way. So they are likely to fall back on their own understanding of what should count as criminal'.<sup>125</sup> It could be argued that juries might not understand the decision-making process of healthcare professionals due to the complexity of scientific facts and evidence in healthcare cases.<sup>126</sup> Therefore, this supports the argument made earlier that the test of gross negligence should be

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<sup>122</sup> D Griffiths, A Sanders, above n14 at 126.

<sup>123</sup> Ibid 135-136.

<sup>124</sup> Ibid.

<sup>125</sup> V Tadros, above n43 at 50.

<sup>126</sup> M Childs, 'Medical manslaughter and corporate liability' (1999) 19(3) *Legal studies* 316, 331.

replaced by recklessness, although this will still involve expert evidence. Moreover, some argue that juries are usually reluctant to convict doctors for GNM, whatever their level of culpability might be.<sup>127</sup> Others suggest that juries are sometimes very in favour of the victims and keen to convict.<sup>128</sup> This shows that the gross test makes juries more vulnerable to lawyers' manipulation.

The criminalisation of reckless conduct rather than gross negligence will help the work of the jury. This will still require that juries be properly guided in their decision but the test of recklessness is easier to explain to juries and it will leave less room for jury or expert interpretation because it is not circular and requires subjective fault. Juries would thus be guided in the assessment of what risks the doctor should have been aware of and if he completely disregarded it.

#### **7.4 Ensuring Healthcare Safety and Responding to Victims' Demands**

Merry argues that legal responses to healthcare error or malpractice are usually motivated by the desire to get compensation, accountability and retribution.<sup>129</sup> Similarly, I have shown that the use of the criminal process is usually motivated by these aims. But does the criminal process effectively achieve these aims in the context of healthcare malpractice? This section will address the question of whether the criminalisation of individual health professionals helps in ensuring healthcare safety and responding to victims' demands for accountability and compensation and seek to draw out how other mechanisms might address these issues.

##### **7.4.1 Ensuring Healthcare Safety**

For criminal law to be efficient in terms of ensuring healthcare safety, it has to deter healthcare professionals from repeating the same conduct in the future and prevent

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<sup>127</sup> O Quick, 'Medical Killing: Need for a Specific Offence?', above n14 at 161.

<sup>128</sup> F Vignaud, 'La judiciarisation de la médecine, comparaison entre droit français et droit américain', in D Dreyfuss, F Lemaire, H Outin (eds), *La judiciarisation de la médecine* (Médecine-Sciences Flammarion 2004) 8; RE Ferner, above n35 at 1213.

<sup>129</sup> A Merry, 'How does the law recognize and deal with medical errors?' (2009) 102 *Journal of the Royal Society of Medicine* 265.

error from occurring again. On criminal liability in general, it is argued that ‘in terms of the well-established purposes of punishment, people need to be deterred from performing dangerous act. Such persons have also demonstrated their dangerousness and need for incapacitation and rehabilitation’.<sup>130</sup> Thus, for deterrence, incapacitation and rehabilitation to be effective, a criminal sentence must be consistent and proportionate to the wrongs. If a sentence is too high or too low, it could lose its value and effectiveness.<sup>131</sup> It seems that the aims of criminal law can only be effective on someone who is aware he has committed a wrong, otherwise he might see the use of the criminal law as unfair and this can lead to defensive behaviour and in the healthcare context, defensive medicine.<sup>132</sup> Thus, there is the necessity of a certain level of moral culpability as proposed earlier. The doctor would have to be aware that he is subjecting another to a risk which he could have avoided.

## **Deterrence and Prevention**

As it has been developed by Robinson and Darley, the prerequisites to deterrence are for an offender to know the legal rules and to be able to analyse the cost-benefit of the crime or compliance.<sup>133</sup> Merry claims that errors cannot be deterred.<sup>134</sup> It is argued that deterrence only works on conduct committed with mens rea.<sup>135</sup> As Hall points out:

The theory of deterrence rests on the premise of rational utility, i.e. that prospective offenders will weigh the evil of the sanction against the gain of the imagined crime. This, however, is not relevant to negligent harm-doers since they have not in the least thought of their duty, their dangerous behaviour, or any sanction [...] In any event, no evidence whatever supports the assumption that, in

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<sup>130</sup> CMV Clarkson, above n114 at 131;

<sup>131</sup> N Allen, ‘Medical or Managerial Manslaughter’, in C Erin, S Ost (eds) *The Criminal Justice System and Health Care* (Oxford University Press 2007) 54.

<sup>132</sup> A Merry, above n1 at 93.

<sup>133</sup> PH Robinson, JM Darley, ‘Does Criminal Law Deter? A Behavioural Science Investigation’, (2004) 24(173) *Oxford Journal of Legal Studies*. 175-182.

<sup>134</sup> A Merry, above n129; A Merry, A McCall Smith, above n9 at 78.

<sup>135</sup> JR Spencer, MA Brajeux, ‘Criminal liability for negligence-A lesson from across the Channel?’ (2010) 59 *International and Comparative Law Quarterly* 19.

some mysterious way, insensitive negligent persons are improved or deterred by their punishment or that of other negligent persons.<sup>136</sup>

Thus, someone who has committed a wrong and recognises that he has committed a wrong might be deterred. Others might be deterred if they also acknowledge that wrong was committed by the defendant.

It has been argued that any legal action against doctors who breached the law has an impact on their reputation and thus has a deterrent effect on them, except when they were only negligent.<sup>137</sup> McCall Smith argues that even 'unexpected deaths ... [are] sufficient to deter even those who would not be deterred by the normal moral repugnance at the thought of being responsible for a patient's death'.<sup>138</sup> Thus, the criminal process is not the only process which might effectively deter doctors who commit malpractice.

On the other hand, it has been argued that fear of punishment encourages individuals to act.<sup>139</sup> Thus, the prospect of punishment could counteract failures to act in the healthcare context. This may be true but the fear of criminal punishment should not give rise to defensive healthcare practice. As Quick states, 'the traditional culture of medicine has been resistant to confronting error, with doctors being schooled in the unrealistic ideal of error-free practice. This, combined with the threat of damaging malpractice litigation, led them to cover up their mistakes, so that even if it allowed individual learning, this was not shared'.<sup>140</sup> Thus, criminal punishment, in order to be deterrent, should be appropriate to the level of wrongful conduct and only blameworthy conduct should be criminalised to ensure that the use of the criminal law will fulfil its proper function.

If criminal law does not deter doctors from committing malpractice or error, criminal proceedings, whatever their outcome, may have an impact on a doctor's reputation

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<sup>136</sup> J Hall, above n4 at 642.

<sup>137</sup> DE Hoffmann, 'Physicians Who Break the Law' (2009) 53(1050) *Saint Louis University Law Journal* 1083.

<sup>138</sup> A McCall Smith, above n26 at 348.

<sup>139</sup> A Garay, 'Vous avez dit "judiciarisation" de la pratique médicale?' in D Dreyfuss, F Lemaire, H Outin (eds), *La judiciarisation de la médecine* (Médecine-Sciences Flammarion 2004) 38.

<sup>140</sup> O Quick, 'Medical Manslaughter: The Rise (and Replacement) of a Contested Crime?', above n14 at 35.

because of the publicity attached to them.<sup>141</sup> Nevertheless, this is also true of other legal proceedings. Doctors may also be deterred by the use of civil, administrative, disciplinary proceedings or effective regulation and inspection. Merry claims that ‘the process also punishes the doctor by its impact on his or her reputation, through the stresses involved in the legal process and through the inevitable publicity associated with it’.<sup>142</sup> Moreover, it is argued that ‘the costs of litigation create an incentive to take safety precautions’.<sup>143</sup> Thus the aim of deterrence could be achieved without necessarily using the criminal process.

The deterrent effect of criminal law on doctors and health officials is not proven.<sup>144</sup> In fact, as McCall Smith suggests:

The prospect of litigation may help to raise standards, and certainly the cautionary tales passed on by defence organisations to their members will help create a climate of carefulness. It would be difficult, though, to gauge the effect of possible prosecution. In the absence of proof to the contrary, it might be suggested that it makes no difference. Few doctors will deliberately expose their patients to risk; there are far more immediate, powerful considerations than prosecution which will prevent this.<sup>145</sup>

In terms of regulatory theory, it is argued that ‘although the criminal justice system may play an important residual role in dealing particularly with repeat offenders and those causing a large amount of social harm, deterrence of regulatory contraventions can adequately be secured by non-criminal processes, provided that financial penalties are available in that context’.<sup>146</sup> Thus, deterrence may be fulfilled by using any legal processes and could be fulfilled by the mistake itself. Thus, the punishment has to be adapted to the profession where the negligence was committed. For example, an appropriate and effective deterrent against healthcare professionals would be to remove their license to practice.

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<sup>141</sup> A Merry, above n129 at 269.

<sup>142</sup> Ibid 270.

<sup>143</sup> MM Mello, TA Brennan, ‘Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform’, (2001) 80 *Texas Law Review* 1603.

<sup>144</sup> J Guigue, above n86 at 36.

<sup>145</sup> A McCall Smith, above n26 at 348.

<sup>146</sup> A Ogus, ‘Regulation and its relationship with the criminal justice system’, in H Quirk, T Seddon, G Smith (eds), *Regulation and Criminal Justice* (Cambridge University Press 2010) 39.

The need for prevention might be addressed by in-depth criminal investigations conducted with the help of medical experts. However, as indicated earlier, they would necessarily have to be publicised and systemic error be analysed. As Hall puts it, ‘the first step toward effective legal control is the recognition of the actual nature of the problem’.<sup>147</sup> Moreover, ‘inappropriate criminal investigation impedes openness in reporting errors, and also inhibits common sense medical practice, particularly in emergencies’.<sup>148</sup> Hence, as I suggested earlier, investigations should be conducted by an authority unrelated to the criminal justice system, but which would have the same means and powers as a JI in the French criminal process.

### **Incapacitation and Rehabilitation**

Can criminal law rehabilitate or incapacitate health professionals who commit malpractice? Again, this may depend on the level of moral wrong involved. Would a doctor who has been convicted of a criminal offence change the way he practises? It has been argued that the aim of rehabilitation would not be met by the use of criminal law against negligent doctors.<sup>149</sup> A criminal sentence might incapacitate a doctor only if he is sentenced to jail.

Disciplinary proceedings are usually better designed to incapacitate and rehabilitate a doctor whose conduct endangers patients. If a doctor has been convicted of a criminal offence or if doubts are raised about his competence, his fitness to practise will be evaluated and he may be placed on probation period, or have his name erased from the Register. Doctors who have been erased from the Register may apply for restoration.<sup>150</sup> This means that a doctor who has been convicted of a criminal offence might be rehabilitated by having his name on the Register after he applied for restoration.<sup>151</sup> However, the effectiveness of disciplinary proceedings in terms of incapacitation and rehabilitation is questioned. Disciplinary proceedings focus on

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<sup>147</sup> J Hall, above n4 at 643.

<sup>148</sup> A Merry, above n1 at 97.

<sup>149</sup> DE Hoffmann, above n137 at 1083.

<sup>150</sup> See <[http://www.gmc-uk.org/doctors/registration\\_applications/restoration.asp](http://www.gmc-uk.org/doctors/registration_applications/restoration.asp)>.

<sup>151</sup> It is important to note that in England every five years, a doctor has to have his licence revalidated and his practice is regularly evaluated according to Good Medical Practice guidances. This might ensure good healthcare practice. See <<http://www.gmc-uk.org/doctors/revalidation.asp>>.



doctors' fitness to practice at the time of the hearing which may be years after the injury or death of a patient. Thus, the doctor may have undergone further training and now be fit to practice and so no sanction is imposed. From the perspective of the victim or the family, the disciplinary process might thus be viewed as limited in ensuring incapacitation and rehabilitation regarding criminal offences, if no action is taken to acknowledge the 'wrong' done. The process of restoration to the register may also raise concerns. Dr Misra who had been convicted of GNM and was subsequently erased from the Register was restored to the Register by the GMC although he had failed a series of medical assessment tests.<sup>152</sup> This example shows that the role of the GMC in allowing doctors to go back to practice even after they have committed a serious criminal offence could undermine victims' confidence in disciplinary proceedings.

#### **7.4.2 Responding to Victims' Demands**

In this subsection, I try to assess whether the criminal process could ensure that victims' demands for restoration, retribution and compensation are correctly addressed.

##### **Restoration**

In healthcare malpractice, criminal law does not restore the initial situation since it does not cure injury or bring back the dead. However, as seen in the blood episode in France and England, victims of healthcare malpractice often ask for 'an acknowledgement of the fact that something has gone wrong, an empathic apology and an explanation'.<sup>153</sup> This could ensure a sort of restoration for the victims. Merry argues that explanations and apologies 'should be given early and readily'.<sup>154</sup> Nevertheless, it is not clear whether the use of criminal proceedings would provide the victims with an apology from the defendant, especially if the defendant shows

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<sup>152</sup> See ch2, 54; A Levy, D Robertson, 'Father's outrage as Indian doctor convicted of son's manslaughter cleared to work again in Britain', *MailOnline*, 29 November 2007.

<sup>153</sup> A Merry, above n129 at 270; A Merry, A McCall Smith, above n9 at 137, 220.

<sup>154</sup> A Merry, above n129 at 270.

defensive behaviour. In the blood contamination criminal proceedings in France, the accused never apologised to the victims.<sup>155</sup>

Looking at the aims of Restorative justice may help us to achieve restoration in the context of healthcare malpractice. Marshall defines Restorative Justice as ‘a process whereby parties with a stake in a specific offence collectively resolve how to deal with the aftermath of the offence and its implications for the future’.<sup>156</sup> Restorative Justice aims to fulfil victims’ material, financial, emotional and social needs, to reintegrate and rehabilitate the offender and to prevent crime.<sup>157</sup> However, ‘Restorative Justice practices rely in large part upon voluntary cooperation. If one party is not willing to participate, the range of options is reduced’.<sup>158</sup> Thus, when doctors are defensive or reluctant to apologise to victims, the aim of restoration might not be fulfilled. Marshall argues that mediation allows the victim and the offender to ‘see each other as persons rather than stereotypes’, as well as to serve the victims’ needs. He claims that mediation affects the offender more than prosecutions and punishment.<sup>159</sup> In cases of healthcare malpractice, it is crucial to ensure that victims and doctors meet to talk about what happened. This could be achieved by other means than the criminal law. It will offer closure to victims and help doctors understand their mistake and improve the way they practice and communicate with patients.

Merry and McCall Smith suggested that mediation between patients and doctors has also proved to be an efficient way to respond to patients’ demands as well as ensuring healthcare safety and prevention.<sup>160</sup> In New Zealand, the Health and Disability Commissioner is in charge of the resolution of disputes between patients and doctors, putting an emphasis on mediation.<sup>161</sup> This could be an example of a development towards mediation that we could use here in England.

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<sup>155</sup> See ch5-6.

<sup>156</sup> TF Marshall, *Restorative Justice: An overview*, Home Office. Research Development and Statistics Directorate (London 1999) 5 <<http://www.homeoffice.gov.uk/rds/pdfs/occ-resjus.pdf>>.

<sup>157</sup> Ibid 6.

<sup>158</sup> Ibid 8.

<sup>159</sup> Ibid 11.

<sup>160</sup> A Merry, A McCall Smith, above n9 at 221.

<sup>161</sup> Ibid.

## Retribution

Garvey states that ‘the *prior-choice* theory claims that retributive punishment for inadvertent lethal risk-creation is justified if and only if the actor’s inadvertence or ignorance was a but-for and proximate result of a prior culpable choice’.<sup>162</sup> On the other hand, ‘the *hypothetical-choice* theory claims that retributive punishment for inadvertent lethal risk-creation is justified if and only if the actor would have chosen to take the risk if he had been aware of it, even though he was not in fact aware of it’.<sup>163</sup> These theories inform us that as for deterrence, the retributive effect of a criminal sanction against an individual depends on his level of moral culpability.<sup>164</sup> Thus, the aim of retribution would only be met in the case of a healthcare professional who has chosen to take an unjustified risk which he was aware of. It is argued that where there is no intent, the aim of retribution is unlikely to be met even though victims might still claim for retributive punishment in cases where the conduct was not morally culpable.<sup>165</sup> The contaminated blood episode in France showed that the criminal process did not respond to the retributive need of the victims.

## Compensation

Victims often ask for compensation for the harm caused. Merry argues that ‘litigation seems an inefficient and unreliable way of providing compensation for harm arising from medical error’.<sup>166</sup> However, when a patient has been a victim of healthcare malpractice, it seems just that she would be compensated. The compensation should be proportionate to the harm caused although it should not encourage victims to use the criminal process only to get compensation. No-fault compensation schemes might be a much more desirable and effective means of compensation to victims of healthcare accidents as they have the potential to rapidly providing greater

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<sup>162</sup> SP Garvey, ‘What’s Wrong with Involuntary Manslaughter?’, (2006), Cornell Law Faculty Publications. Paper 53. See <[http://scholarship.law.cornell.edu/lrsp\\_papers/53](http://scholarship.law.cornell.edu/lrsp_papers/53)> 1. Ibid.

<sup>163</sup> Ibid.

<sup>164</sup> Ibid; HLA Hart, *Punishment and Responsibility, Essays in the Philosophy of Law* (2<sup>nd</sup> edn, Oxford University Press 2008) 231.

<sup>165</sup> DE Hoffman, above n137 at 1084.

<sup>166</sup> A Merry, above n129 at 270.

compensation than the criminal process. However we should not underestimate the limits of no-fault compensation schemes, which I discuss in the next section.

## **7.5 Alternatives to the Criminal Process**

I have argued that the use of the criminal process should be reserved for instances of healthcare malpractice where a health professional has acted without regard for the safety of the patient, a case which Merry and McCall Smith would deem violations. Nor do other grounds for resort to the criminal law seem readily applicable. It follows that for the most part, I would not endorse the more extensive use of the criminal process applicable in France. However, there are certain aspects of the French criminal process that meet the needs of victims in terms of transparency and understanding and this section considers how those benefits could be secured outside the criminal process.

### **7.5.1 Disciplinary Proceedings**

In both France and England, disciplinary procedures can be undertaken against health professionals. In France, the *Ordre des Médecins* is the disciplinary body in charge of judging doctors and other health professionals when they have breached the *Code de déontologie*. In England, the GMC is in charge of disciplinary procedures against health professionals. The aim would be to make sure that doctors go back to good practice and learn from their errors. Disciplinary proceedings could ensure ‘that the circumstances of the negligence are fully investigated and measures put in place to minimise the chance of repetition, if necessary by preventing the negligent doctor from continuing to practice medicine’.<sup>167</sup>

In disciplinary proceedings in both countries, doctors have usually been judged by their peers. However, since the creation of the Medical Practitioners Tribunal Service (MPTS) in June 2012 in England, doctors are not completely judged by their peers in disciplinary proceedings anymore and proceedings are thus in theory more

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<sup>167</sup> M Brazier, A Alghrani, ‘Fatal Medical Malpractice and Criminal Liability’ (2009) 25(2) *Journal of Professional Negligence* 51, 63.

independent and impartial.<sup>168</sup> The MPTS seems to address some of the concerns raised earlier about investigations conducted by non-medical specialists in criminal proceedings as the MPTS has a number of medical panellists and has the potential to be an efficient alternative to the criminal process in ensuring healthcare safety and responding to victims' demands. It runs independent and impartial hearings on a doctor's fitness to practise according to standards set by the GMC.<sup>169</sup> It has the power to impose sanctions against a doctor's registration. The role of the MPTS is totally separated from the GMC's investigatory function. Thus, the impartiality and independence of the MPTS addresses suggestions made earlier about the need of an independent body to investigate healthcare malpractice cases. In France, doctors are still judged by their peers in disciplinary proceedings except on appeal where an administrative judge preside trials.<sup>170</sup>

Disciplinary proceedings are necessary to regulate the medical profession and ensure good medical practice. Nevertheless, are disciplinary proceedings sufficient when appalling care has been given and a patient has died or has been fatally injured? Moreover, victims or their families may not see non-criminal proceedings as sufficient to meet their needs for retribution.<sup>171</sup>

### **7.5.2 Prevention, Reporting and Precautionary Principle**

Quick states that 'recent attention to medical error has seen the eschewal of the model of individual blame which has characterized the approach to healthcare errors in favour of encouraging a culture of open disclosure and reporting'.<sup>172</sup> Merry suggests that a way to ensure healthcare safety is to encourage open reporting of things which go wrong.<sup>173</sup> He argues that 'people are less likely to report fully, frankly, and promptly if they fear that the consequences of doing so might include

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<sup>168</sup> New statutory rules governing the MPTS's procedures are expected to be approved by the Parliament in 2013. See <[www.mpts-uk.org/about/1595.asp](http://www.mpts-uk.org/about/1595.asp)>.

<sup>169</sup> See <[www.mpts-uk.org/about/1595.asp](http://www.mpts-uk.org/about/1595.asp)>.

<sup>170</sup> See <<http://www.conseil-national.medecin.fr/les-missions-1207>>.

<sup>171</sup> M Brazier, A Alghrani, above n167 at 8.

<sup>172</sup> O Quick, 'Medical Manslaughter: The Rise (and Replacement) of a Contested Crime?', above n14 at 35.

<sup>173</sup> A Merry, above n1 at 93.

criminal charges'.<sup>174</sup> In France, it was argued that the healthcare system should learn from the industrial model of risk management and create a national agency of health risk management.<sup>175</sup> This agency would provide expert reports on health professionals' practice so that they and other health professionals can learn from their experience.<sup>176</sup> In England, the National Patient Safety Agency (NPSA) was created in 2001. It included the National Clinical Assessment Service which 'supports the resolution of concerns about the performance of individual clinical practitioners', as well as the Patient Safety Division which ensured patient safety in identifying and addressing risks to patients.<sup>177</sup> In June 2012, the patient safety functions of the NPSA were transferred to the NHS Commissioning Board Special Health Authority, to ensure that 'patient safety is at the heart of the NHS and builds on the learning and expertise developed by the NPSA, driving patient safety improvement'.<sup>178</sup> The effectiveness of this new body will have to be assessed in practice to consider whether it is a good alternative to the criminal process or makes it less necessary in the healthcare malpractice context.

Merry and McCall Smith argue, 'proactive measures to promote and enforce high standards on a day-to-day basis are much more likely to improve safety and quality than the threat of litigation'.<sup>179</sup> The analysis of the blood episode in France and England has highlighted the need to increase prevention in the healthcare context. The episode was followed in France by the creation of the precautionary principle which holds that precautionary measures should be taken when a potential risk to healthcare is known.<sup>180</sup> I will discuss the relevance of this principle in the next chapter in the context of systemic failure.

### 7.5.3 Transparency and Investigations

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<sup>174</sup> Ibid.

<sup>175</sup> AM Ceretti, 'Responsabilité médicale: le point de vue du lien', in D Dreyfuss, F Lemaire, H Outin (eds), *La judiciarisation de la médecine* (Médecine-Sciences Flammarion 2004) 42.

<sup>176</sup> Ibid.

<sup>177</sup> See <<http://www.npsa.nhs.uk/corporate/about-us/what-we-do/>>.

<sup>178</sup> See <<http://www.npsa.nhs.uk/corporate/news/transfer-of-patient-safety-function/>>.

<sup>179</sup> A Merry, A McCall Smith, above n9 at 214.

<sup>180</sup> E Hergon et al., 'Risk Management in Transfusion After the HIV Blood Contamination Crisis in France: The Impact of the Precautionary Principle' (2005) 19(4) *Transfusion Medicine Reviews* 273.

In Chapter 6, I highlighted the importance of investigations conducted on the HIV-contaminated blood episode.<sup>181</sup> However, I have shown that the Archer Inquiry, which was not a public inquiry, had limits. Public inquiries could be an answer but they may be costly and time consuming. There is thus a need to find a cost effective and rapid means of investigations which could effectively provide transparency and closure on healthcare malpractice cases. Only when the victim has died, this could be handled by coroners, inspired by the New-Zealand model of commissioners.<sup>182</sup>

#### 7.5.4 No-fault Compensation

As argued earlier, sufficient compensation needs to be provided to victims of healthcare malpractice. Earlier in the chapter, I have mentioned the use of no-fault compensation schemes as is the case in France for medical accidents. Civil compensation has to be sufficient to cover lost income, necessary expenses, and moral and physical damages. In the contaminated blood episode in England, victims complained that ex gratia payments were too low. Effective and sufficient compensation could ensure that the desire for recourse to legal proceedings and particularly criminal proceedings is reduced but there is not at present enough evidence to assess whether this would work in practice.

Since the creation of a new out-of-court settlement scheme of civil compensation for victims of medical accidents in France in 2002, victims of serious medical accidents can get rapid compensation for the harm caused. They can ask for experts report to regional commissions in charge of the compensation.<sup>183</sup> All victims also receive the support of a conciliation service which then would address the concerns made earlier about the role of the criminal law in mediation and could offer the victims with some restoration.<sup>184</sup>

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<sup>181</sup> See Ch6.

<sup>182</sup> See P Skegg, 'A Fortunate Experiment?: New Zealand's Experience With A Legislated Code of Patients' Rights' (2011) 19 *Medical Law Review* 235, 247.

<sup>183</sup> Loi n° 2002-303 du 4 mars 2002 relative aux droits des maladies et à la qualité du système de santé; N Gombault, 'Conséquences de la judiciarisation de la médecine dans la relation médecin-malade' in D Dreyfuss, F Lemaire, H Outin (eds), *La judiciarisation de la médecine* (Médecine-Sciences, Flammarion 2004) 2.

<sup>184</sup> See pt7.4.2; See <<http://www.oniam.fr/crci/presentation/>>.

This reform could have reduced the number of criminal complaints and civil claims for compensation against medical professionals in criminal courts. However, the actual efficiency of the new scheme in reducing the number of criminal prosecutions is difficult to assess because of the lack of statistics in that area.<sup>185</sup> Taylor argues that the scheme is limited to serious cases and this is one of its weaknesses.<sup>186</sup> He claims that the system is also very complex due in particular to the uncertain notion of fault and causation difficulties for the commissions.<sup>187</sup> The scheme has the advantage of providing full compensation to victims of serious medical accidents but this leaves aside a great number of victims. Taylor argues that providing full compensation to a greater number of victims than the French system in England would not seem possible, although the French scheme is to be regarded as a 'potential model for reform' in England.<sup>188</sup>

In Scotland in 2009, a review group was formed to consider the advantages of having a no-fault scheme for medical accidents.<sup>189</sup> The Review considered that the advantages of no-fault compensation schemes include full rehabilitation, fair and adequate compensation, efficiency in terms of time and costs, improving relationships between patients and healthcare practitioners, learning from error and enhancing patient safety. However, the review noted that compensation schemes may fail to promote accountability, explanations and apologies from health practitioners to patients, prevent unsafe practices by healthcare professionals, and promote the development of a compensation culture. The review stated that it is sometimes difficult to prove causation and no-fault compensation schemes have significant rejection rates due to the failure to satisfy eligibility criteria. It also acknowledged that there is not enough evidence to prove that no-fault compensation schemes help in learning from medical error.<sup>190</sup>

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<sup>185</sup> S Taylor, 'Providing Redress for Medical Accidents in France: Conflicting Aims, Effective Solutions?' (2011) 2(1) *Journal of European Tort Law* 57, 69.

<sup>186</sup> S Taylor, 'Clinical negligence reform: lessons from France?' (2003) 52 *International and Comparative Law Quarterly* 737, 745-746.

<sup>187</sup> *Ibid* 746.

<sup>188</sup> *Ibid* 747.

<sup>189</sup> AM Farrell, S Devaney, A Dar, No-fault Compensation Schemes for Medical Injury: A Review', Scottish Government Social Research, 2010, 7.

<sup>190</sup> *Ibid* 9-10; The Scottish Government looked at the review in a consultation which ended in November 2012, See <<http://www.scotland.gov.uk/Publications/2012/08/4456>>.



Thus, no-fault compensation schemes seem to be potential responses to the need for compensation for patients who were victim of healthcare accidents. However, they need to be improved to mitigate some of the disadvantages enumerated above.

### 7.5.5 Healthcare Practice

Different aspects of the way in which healthcare is delivered have an indirect impact on the likelihood of resort to criminal law. For example, in the contaminated blood episode, the lack of communication between Haemophilia doctors and other scientists and medical professionals was highlighted in the *Sénat*'s inquiry as being one of the causes of the HIV-contamination of the blood supply.<sup>191</sup> The lack of training and communication among hospital staff members and between doctors and patients was also identified in several healthcare malpractice cases in France and England.<sup>192</sup> The doctors' arrogance and reluctance to admit that they had committed a wrong or mistake were said to be some of the motivations of victims for using the criminal law.<sup>193</sup> Perhaps a way to reduce the use of the criminal law against medical professionals would be to improve the delivery of healthcare, in particular the quality of communication between health professionals themselves and between health professionals and patients.<sup>194</sup>

## 7.6 Conclusion

'Error will never be completely eliminated, and there will always be some doctors whose behaviour is frankly culpable'.<sup>195</sup> Criminal law should be used to criminalise only conduct which demonstrated obvious disregard or indifference to a risk to the

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<sup>191</sup> J Sourdille, C Huriet, *La crise du système transfusionnel français*, Rapport de la commission d'enquête du Sénat (Economica 1992) 55.

<sup>192</sup> *R v Prentice*; *R Sullman* [1994] QB 302; TGI de Paris, 16<sup>e</sup> Chambre, jugement du 3 septembre 2003, affaire n° 9926423046; Unknown author, 'Doctor charged over death', *The Guardian*, 7 March 1995; RE Ferner, above n35 at 1212.

<sup>193</sup> Interview with Marie-Odile Bertella-Geffroy (Paris, France, 18 January 2011); J Guigue, above n86 at 36.

<sup>194</sup> JF Burgelin, 'Quelques conclusions' in D Dreyfuss, F Lemaire, H Outin (eds), *La judiciarisation de la médecine* (Medecine-Sciences Flammarion 2004) 45.

<sup>195</sup> A Merry, A McCall Smith, above n9 at 3.

life of another. The French model of criminalising doctors for simple negligence should not be followed in England.

Injury short of death and omissions to act should be criminalised when the conduct was morally blameworthy to limit the scope for moral luck. Here, French substantive criminal law should be used as an example for the English system. Offences such as *blessures involontaires* and *non-assistance à personne en danger* could be copied into English criminal law. English criminal law has the potential to achieve this without the need of significant reforms. Two offences could be used here: GNM should be replaced by reckless manslaughter and section 20 of the OAPA 1861 should be used in healthcare malpractice cases.

In terms of criminal procedure, the powers and means of the *juge d'instruction* should perhaps be considered as a model for in-depth investigations. The current test of gross negligence should be abandoned and replaced by recklessness to ensure consistency in prosecutions of healthcare practitioners and proper guidance of the jury. The role of victims in French criminal procedure has highlighted the need to ensure that transparency, accountability, prevention, retribution, closure and compensation are achieved in healthcare malpractice cases. These aims could be fulfilled by the use of alternative proceedings such as disciplinary proceedings, open-reporting mechanisms, mediation, public inquiries and compensation schemes. Merry and McCall Smith argue:

A better understanding of the factors which underlie the different types of human failing associated with iatrogenic harm is the fundamental requirement for improving the way in which we regulate medicine and compensate those who are harmed in the course of receiving treatment.<sup>196</sup>

The French no-fault compensation scheme should be used as a model in England to allow victims who did not have access to or chose not to use legal proceedings to obtain compensation for their harm, although reforms in this area are not at present likely to happen.

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<sup>196</sup> Ibid.

## 8. Corporate Criminal Responsibility is not the Answer?

### 8.1 Introduction

The National Health Service (NHS) is not only the largest employer in the country but also of course its core role means that it runs a greater than average risk that harm may result from its procedures.<sup>1</sup>

Should this greater risk of harm prompt a greater emphasis on and justify the use of the criminal process against NHS institutions and so help in promoting healthcare safety?

It has been argued that an effective alternative to the use of criminal law against individuals would be corporate criminal liability in the context of healthcare malpractice, in particular under the Corporate Manslaughter and Corporate Homicide Act 2007 (CMCH 2007).<sup>2</sup> In this chapter, I argue against the trend which advocates corporate criminal liability as an appropriate and effective alternative to problems arising from individual criminal liability in the context of healthcare malpractice. I suggest that corporate criminal liability is unlikely to achieve a greater degree of healthcare safety and respond to victims' demands. The role of corporate liability in the healthcare malpractice context is limited in much the same way as for individual criminal redress. We should note that in England, a more effective form of criminal redress is available under the Health and Safety at Work Act 1974 (HSWA 1974). We should see the limited role of the criminal process in the wider context taking into account the role of the Care Quality Commission (CQC) in prosecutions for healthcare malpractice.

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<sup>1</sup> C Wells, 'Medical manslaughter-organisational liability', in D Griffiths, A Sanders (eds), *Medicine, Crime and Society* (Cambridge University Press Forthcoming 2013) 192.

<sup>2</sup> O Quick, 'Medicine, mistake and manslaughter: a criminal combination' (2012) 69(1) *Cambridge Law Journal* 186; N Allen, 'Medical or Managerial Manslaughter' in C Erin, S Ost (eds), *The Criminal Justice System and Health Care* (Oxford University Press 2007) 50-66; C Wells, above n1; P Gooderham, 'No-one fully responsible': a 'collusion of anonymity' protecting health care bodies from manslaughter charges? (2011) *Clinical Ethics* 68.

As explained in Chapter 2, in France, the *Code Pénal* once again admits a wider scope for criminalisation than England in the context of corporate healthcare malpractice. Under French criminal law, health institutions can be charged with any of the negligence offences set out in Chapter 2.<sup>3</sup> Under current English criminal law, corporate misconduct can be criminalised by corporate gross negligence manslaughter under the Corporate Manslaughter and Corporate Homicide Act 2007 (CMCH 2007) and/or Health and Safety offences under the HSWA 1974.<sup>4</sup>

I will argue that corporate healthcare malpractice, as individual healthcare malpractice, should only be criminalised where there is evidence of recklessness within the organisation and corporate criminal liability should not only depend on outcome. Borrowing from the French model and as I argued in the previous chapter, failure resulting in non-fatal injury should be criminalised at the corporate level. Offences under the HSWA 1974 might be a more appropriate answer than liability under the CMCH 2007, and a duty to rescue should be recognised in English criminal law to hold regulators liable. I do not endorse the criminalisation of simple negligence at the corporate level as France does.

The criminal process will not relate to all health institutions in the same way. A distinction should be made between different NHS health institutions in England as their different roles will and should not give rise to the same sort of liability. A distinction must be made between institutions which commission care and institutions which directly provide care. These institutions are at different levels of the decision-making process in the health service and face different levels of risk. Institutions providing care confront higher and more immediate risk to patient safety than those which commission care, mainly because providers are in direct contact with patients. Currently, Primary Care Trusts (PCTs) soon to be replaced by Clinical Commissioning Groups (CCGs) are responsible for commissioning secondary care such as hospital care. Secondary care is generally

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<sup>3</sup> See Ch2 pt2.3.2, 47.

<sup>4</sup> Art 121-2 Code Pénal (CP); Corporate Manslaughter Act and Corporate Homicide Act 2007 (CMCH 2007) s1; HSWA 1974 s3.

provided by NHS Trusts or Foundation Trusts and other institutions, including private sector organisations.<sup>5</sup>

The blood episode has shown that the failure to respond to the contamination of the blood supply was in part a result of diffused levels of responsibility in the decision-making process. The blood episode was one example of a common problem which often arises in healthcare malpractice episodes which sometimes appear at first to result from individual failure. Among many others, the *Sullman and Prentice* case and the *Ubani* case fall into this category.<sup>6</sup> The focus for criminal charges picked out just one or two individuals at the end of a long chain of failures to protect the patient. Criminal proceedings arising out of the blood episode in France illustrated the preference of the victims and the *juge d'instruction* (JI) for using individual criminal liability rather than corporate liability. *Juges d'instruction* looked for culpability on the part of each person involved in the decision-making process.

Here, I suggest that a more sensible approach to problems arising from failure at the public level would be to put the focus on individuals who have the power to change unsafe practice as happened in part in France in the blood episode. In theory, criminalising regulators and decision-makers when they have failed recklessly on their obligations might more effectively ensure that safe practice is carried out in the whole system. However, as shown in the blood episode and in several inquiries which involved failure in health services, it is often hard to identify accountable individuals, or even accountable institutions, since responsibilities are often so disseminated, and responsible individuals and institutions are often too remote to prove a causal link.<sup>7</sup> I will however seek to show that some features of the French criminal process may be used to regulate corporate healthcare malpractice without having to recourse to criminal proceedings.

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<sup>5</sup> This thesis was completed before most of the provisions of the Health and Social Care Act 2012 came into force.

<sup>6</sup> P Gooderham, above n2.

<sup>7</sup> Ibid.

## 8.2 Should Health Institutions be Criminally Liable for Malpractice?

Did you ever expect a corporation to have a conscience, when it has no soul to be damned, and no body to be kicked?<sup>8</sup>

Edward, First Baron Thurlow 1731-1806

As I have done throughout this thesis, in this chapter I argue that only disregard to life and safety on the part of health institutions should normally attract criminal liability. I will later suggest that the HSWA 1974 provides for a more appropriate criminalisation of health institutions for malpractice than the CMCH 2007 even though recklessness is not required to be proved under the HSWA 1974. I will however point out that the CMCH 2007 contains useful aspects to counteract corporate healthcare malpractice.

In previous chapters, we have seen examples of healthcare malpractice caused by systems error. For instance, in *Prentice and Sullman*, vincristine was wrongly injected into a patient's spine. The negligence was in part the result of a lack of supervision of the two junior doctors and a misunderstanding of each doctor's responsibility as well as the failure to read the drug's label which indicated how vincristine was to be administered. It was also shown that the cytotoxic drugs had been placed on the lumbar-puncture trolley without the manufacturer's data-sheet, which misled the two doctors.<sup>9</sup> The judge sentencing the two doctors thus affirmed that they 'could have been helped more than [they] were helped'.<sup>10</sup> Merry states that 'removing the last person in the chain of errors without fixing the predisposing factors simply sets the stage for the same thing to happen again to someone else'.<sup>11</sup>

Similarly, Doctor Ubani had prescribed an inappropriate dose of diamorphine to a patient who died as a result. The causes of his failure were said to be his poor English, his unfamiliarity with the product and his fatigue. Gooderham made an

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<sup>8</sup> Quoted in JC Coffee, 'No Soul to Damn: No Body to Kick': An Unscandalized Inquiry into the Problem of Corporate Punishment' (1981) 79(3) *Michigan Law Review* 386.

<sup>9</sup> *R v Prentice; R v Sullman* [1993] 4 All ER 935 at 945.

<sup>10</sup> *R v Prentice* [1993] 3 WLR 927.

<sup>11</sup> A Merry, 'When Are Errors a Crime?-Lessons from New Zealand', in C Erin, S Ost (eds), *The Criminal Justice System and Heath Care* (Oxford University Press 2007) 81.

analysis of all the agencies involved in the appointment of Ubani as an out-of-hours GP. He discovered that six institutions could potentially have been held to account for Ubani's error.<sup>12</sup> In the contaminated blood episode, failure to respond to the contamination had resulted in part from the disorganisation of the healthcare system and misunderstanding of each actor's role and responsibility which was acknowledged in the several inquiries in the episode.<sup>13</sup>

The difficulty raised by corporate personality and responsibility is the determination of any mens rea when committing a criminal offence.<sup>14</sup> As explained in Chapter 2 in France, corporations may be convicted of all criminal offences applicable to individuals.<sup>15</sup> The criminalisation of corporations is nonetheless not exclusive.<sup>16</sup> In the same criminal proceedings, both corporations and individuals may be prosecuted and convicted.<sup>17</sup> For a corporation to be criminalised, a criminal offence has to be committed by one of its bodies or representatives on its behalf.<sup>18</sup> Thus, if the corporation's representative has committed an offence, the corporation may be subject to criminal liability.<sup>19</sup> I argue later that this model should not be followed.

Before 2008 in England, corporations could be convicted of common law manslaughter or health and safety offences. To use common law corporate manslaughter, courts had to choose between using direct corporate liability, vicarious liability or the identification doctrine.<sup>20</sup> According to the doctrine of

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<sup>12</sup> P Gooderham, above n2 at 69.

<sup>13</sup> See Ch4; J Sourdille, C Huriet, *La crise du système transfusionnel français*, Rapport de la commission d'enquête du Sénat (Ecomonica 1992) 43-44; Assemblée Nationale, *Rapport de la commission d'enquête sur l'état des connaissances scientifiques et les actions menées à l'égard de la transmission du sida* (Union générale d'édition 1993) 14.

<sup>14</sup> J Gobert, 'Corporate criminality: Four models of fault' (1994) 14(3) *Legal studies* 395.

<sup>15</sup> Art 121-2 CP; there are nonetheless certain limits regarding the criminalisation of *collectivités territoriales* (local authorities).

<sup>16</sup> Art 121-2 CP.

<sup>17</sup> Ibid.

<sup>18</sup> Ibid; B Bouloc, H Matsopoulou, *Droit pénal général et procédure pénale* (17<sup>e</sup> edn, Sirey 2009) 153; Assemblée Nationale, Rapport n° 2266 fait au nom de la commission des lois constitutionnelles, de la législation et de l'administration générale de la République sur la proposition de loi, adoptée par le Sénat, tendant à préciser la définition des délits non intentionnels, par M René Dosièrre, 22 mars 2000, 53.

<sup>19</sup> But the French courts have admitted that even if the directing mind of the corporation was not found guilty in the proceedings, the corporation could still be convicted of a criminal offence. CA Grenoble, 12 juin 1998, affaire du Drac.

<sup>20</sup> S Parsons, 'The doctrine of identification, causation and corporate liability for manslaughter' (2003) 67 *Journal of Criminal Law* 69; N Allen, above n2 at 60-62.

vicarious liability, the company was criminally liable for the acts of senior managers and employees.<sup>21</sup> The identification doctrine provided that if only the governing authority of a corporation had committed an offence, then the whole corporation was liable for the offence.<sup>22</sup> The identification doctrine provided limited scope for the criminalisation of corporations.<sup>23</sup> The mens rea of the institution was present in the controlling minds or senior managers of the institution.

Here, I argue that if the controlling mind or regulator of the institution has committed a morally blameworthy action or omission which has caused death or injury, he should be convicted of a criminal offence rather than the whole corporation. While arguing in favour of corporate liability in the healthcare malpractice context, Toft and Gooderham suggest that ‘where managers have been warned of an unsafe system, and reasonable action has not been taken, then liability, particularly criminal liability for manslaughter, should fall more upon managers and corporate bodies and less upon individuals’.<sup>24</sup> I will propose later that if the harm was caused by a combination of several errors, criminal law is not useful to ensure healthcare safety. Rather review mechanisms and inquiries may be more effective in that context.

In all other cases ie when an error was a consequence of systemic failure and not of recklessness on the part of ‘directing minds’, criminalising the institution is not an appropriate alternative to criminalising individuals but I acknowledge the usefulness of offences under the HSWA 1974. If several people involved in the decision-making process which led to the error did commit morally wrong actions or omissions, they should be subject to criminal liability when they showed obvious disregard to health and safety, as argued in Chapter 7.<sup>25</sup> If no single person or institution caused the harm and only the combination of

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<sup>21</sup> J Gobert, above n14 at 396.

<sup>22</sup> N Allen, above n2 at 56; *Lennards Carrying Co. Ltd v Asiatic Petroleum Ltd* [1915] AC 705, HL; *DPP v Kent and Sussex Contractors* [1944] KB 146, DC; *R v ICR Haulage Ltd* [1944] KB 551, CCA; *Tesco Supermarkets Ltd v Natrass* [1972] AC 153 (HL).

<sup>23</sup> S Parsons, above n20 at 70.

<sup>24</sup> P Gooderham, B Toft, ‘Involuntary automaticity and medical manslaughter’ in D Griffiths, A Sanders (eds), *Medicine, Crime and Society* (Cambridge University Press Forthcoming 2013) 188.

<sup>25</sup> See Ch7 pt7.2.1, 201.



systemic failures created culpability, criminal law does not seem to be the right answer to make sure that similar failures do not recur because the system has failed as a whole and it would be impossible to prosecute the whole system. A distinction must be made between the use of the criminal law designed to address acts and failures for which there is culpability and offences addressing regulatory lapses. Even though I will argue that health and safety offences may respond to some of the concerns present in corporate liability for healthcare malpractice, preventive mechanisms and better regulation seem to be more appropriate responses to such a problem.

### **8.3 Corporate Offences Applied to Healthcare Malpractice**

In this section, I demonstrate that the current criminalisation of health institutions under the CMCH 2007 is not completely suitable for criminalising health institutions while suggesting that some of CMCH 2007's features may be used in alternative proceedings to the criminal process to improve health and safety and respond to victims' demands.

On the other hand, I argue that in certain cases, the HSWA 1974 seems to be a more useful tool to counteract corporate healthcare malpractice. I do not argue for the criminalisation of health institutions for the same offences as for individuals as in France, but I suggest that health institutions should also be criminalised for offences resulting in injury short of death because as for individuals, corporate criminal liability should not solely depend on outcome.

#### **8.3.1 Liability under the Corporate Manslaughter and Corporate Homicide Act 2007 (CMCH 2007)**

Currently, under the CMCH 2007, a corporation is criminally liable 'if the way in which its activities are managed or organised (a) causes a person's death and (b) amounts to a gross breach of a relevant duty of care owed by the organisation

to the deceased’.<sup>26</sup> The condition is that the way in which the corporation’s activities are ‘managed or organised by its senior management must be a substantial element in the breach’.<sup>27</sup> Section 1 (4) (b) indicates that ‘a breach of a duty of care by an organisation is a “gross” breach if the conduct alleged to amount to a breach of that duty falls far below what can reasonably be expected of the organisation in the circumstances’.<sup>28</sup> This implies that a duty of care must be owed to the individual and thus does not take into account a situation where an institution did not owe a duty of care to the individual as was the case in the HIV litigation in England.<sup>29</sup> ‘Senior management’ refers to the ‘persons who play significant roles in (i) the making of decisions about how the whole or a substantial part of its activities are to be managed or organised, or (ii) the actual managing or organising of the whole or a substantial part of those activities’.<sup>30</sup>

Gooderham argues that ‘the Act offers more guidance to a jury on what constitutes a breach of duty than [GNM]’.<sup>31</sup> The Act however is not clear on what is to be considered ‘substantial’. So far, the Act seems however apt to embrace many cases where an NHS body, which owed a duty of care to the individual, would have been grossly negligent and caused the death of a patient. However, it could not apply to regulators who may not owe a duty of care to individuals. For instance, it could not have applied to blood centres in the HIV-contaminated blood episode in England.<sup>32</sup>

As Wells and Gooderham pointed out, the Act admits a large range of exceptions.<sup>33</sup> First, included in a ‘relevant duty of care’ of an organisation are

- (a) a duty owed to its employees or to other persons working for the organisation or performing services for it; (b) a duty owed as occupier of premises; (c) a duty owed in connection with (i) the supply by the organisation of goods or services, (ii) the carrying on by the organisation of

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<sup>26</sup> CMCH 2007 s1(1).

<sup>27</sup> CMCH 2007 s1(3).

<sup>28</sup> CMCH Act 2007 s 1 (4)(b).

<sup>29</sup> See ch6 pt6.3.2, 181.

<sup>30</sup> CMCH Act 2007 s1 (4)(c).

<sup>31</sup> P Gooderham, above n2 at 71.

<sup>32</sup> See HIV litigation in Ch6.

<sup>33</sup> C Wells, above n1 at 202; P Gooderham, above n2 at 71.

any construction or maintenance operations; (iii) the carrying on by the organisation of any other activity on a commercial basis, or (iv) the use or keeping by the organisation of any plant, vehicle or other thing.<sup>34</sup>

For instance, if an NHS Trust commissions a clinical service, it would be considered to be supplying a service and will thus owe a duty of care.<sup>35</sup>

Nevertheless, according to Section 3(1) of the Act, ‘any duty of care owed by a public authority in respect of a decision as to matters of public policy (including in particular the allocation of public resources or the weighing of competing public interests) is not a “relevant duty of care”’.<sup>36</sup> For example, an institution might decide not to provide a particular drug for financial reasons.<sup>37</sup> We may thus think that it would have been difficult to use the CMCH 2007 against the national blood supply in England during the blood episode had the Act been in force at the time.

Similarly, ‘any duty of care owed in respect of things done in the exercise of an exclusively public function is not a “relevant duty of care” unless the duty is ‘owed to its employees or to other persons working for the organisation or performing services for it’; the duty is ‘owed as occupier of the premises’; or it is ‘owed to a person who [...] is someone for whose safety the organisation is responsible’.<sup>38</sup> In the blood episode, this would have meant—if similar legislation had been in force in France—that the *Centre National de Transfusion Sanguine* (CNTS) owed a duty of care to Haemophilia patients and thus would have been liable under the Act.

Lastly, is not a “relevant duty of care” a duty ‘owed by a public authority in respect of inspections carried out in the exercise of a statutory function’ unless the duty is ‘owed to its employees or to other persons working for the organisation or performing services for it’, or it is ‘owed as occupier of

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<sup>34</sup> CMCH 2007 s 2.

<sup>35</sup> C Wells, above n1 at 202-203.

<sup>36</sup> CMCH 2007 s3(1).

<sup>37</sup> P Gooderham, above n2 at 71.

<sup>38</sup> CMCH 2007 s3(2) and s2(1)(a), (b), (d).

premises’.<sup>39</sup> Thus, this could not apply to the CQC which regulates hospitals to check if they meet safety standards.<sup>40</sup>

The Act notes that an ‘exclusively public function’ is one that ‘falls within the prerogative of the Crown or is, by its nature, exercisable only with authority conferred (a) by the exercise of that prerogative, or (b) by or under a statutory provision’, which is a ‘function conferred by or under a statutory provision’.<sup>41</sup> The Ministry of Justice Notes on the Act provide that this includes licensing drugs.<sup>42</sup> Wells indicates that this excludes a function which required a licence or ‘took place on a statutory basis’ and this means that ‘NHS liability that previously existed under common law manslaughter would be removed altogether’.<sup>43</sup>

The Act also admits a large number of exceptions in the area of emergencies. Section 6 of the Act provides that ‘any duty of care owed by an organisation [...] in respect of the way in which it responds to emergency circumstances is not a “relevant duty of care” unless it is ‘owed to its employees or to other persons working for the organisation or performing services for it’, or it is ‘owed as occupier of premises’.<sup>44</sup> This includes ‘relevant NHS’ bodies (Strategic Health Authority, Primary Care Trusts-and will then probably cover CCGs-, NHS Trust, Special Health Authority or NHS Foundation Trust in England), organisations ‘providing ambulance services’ or ‘providing services for the transport of organs, blood, equipment or personnel in pursuance of arrangements (i) made by, or at the request of, a relevant NHS body, or (ii) made with the Secretary of State or with the Welsh Ministers’, and organisations ‘providing a rescue service’.<sup>45</sup> Section 6(7) of the Act further indicates that ‘emergency circumstances’ include circumstances which ‘(a) are causing, or are likely to cause, serious harm or a worsening of such harm, or (b) are likely to cause the death of a person’.<sup>46</sup> This means that if an ambulance comes to rescue someone and causes the death of that

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<sup>39</sup> CMCH 2007 s3(3) and s2(1)(a), (b).

<sup>40</sup> See <<http://www.cqc.org.uk/>>.

<sup>41</sup> CMCH 2007 s3(4).

<sup>42</sup> Explanatory Notes to CMCH 2007 para 27.

<sup>43</sup> C Wells, above n1 at 202.

<sup>44</sup> CMCH 2007 s6(1) and s2(1)(a), (b).

<sup>45</sup> CMCH 2007 s 6(1), (2)(e), (f), (g), (h) and s6(7)(a).

<sup>46</sup> CMCH 2007 s6(7)(a)(b).

person by treating him with gross negligence, the ambulance Trust cannot be criminally liable under the Act.<sup>47</sup>

Thus, the Act seems to exclude from liability a substantial proportion of health institution activities that might cause harm as a result of serious failure. Wells argued, ‘the Act is complex and the offence definition itself is full of ambiguities and interpretive uncertainty’ and thus does not provide with a satisfactory and efficient criminalisation of healthcare institutions.<sup>48</sup> The CMCH 2007 seems to make it difficult to prosecute an institution for malpractice. Gooderham also noted that in a case such as *Ubani*, ‘the fragmented nature of the corporate NHS [...] makes it difficult to apply elements of the offence contained in the Act to anyone of the corporate bodies involved’.<sup>49</sup>

Again, English criminal law shows limits in the criminalisation of corporate negligence, contrary to France. What might be learned from France? The same point made in the previous chapter should be made here. If we are to criminalise corporate negligence, there is no reason why it should be limited to conduct resulting in death and to certain institutions only-those which owe a duty of care. Why should a company be convicted of manslaughter where another one that committed the same level of wrong would not be convicted because it only caused injury, because it did not owe a duty of care, either in the absence of a duty to rescue or because it fell under the exceptions of the Act?

### **8.3.2 Liability under the Health and Safety at Work Act 1974 (HSWA 1974)**

Following the French model, whenever a health institution could be held criminally liable for malpractice, conduct resulting in injury short of death should also be criminalised. As argued in the previous chapter, luck and outcome should not be taken into account when criminalising malpractice and this should apply

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<sup>47</sup> C Wells, above n1 at 203.

<sup>48</sup> C Wells, above n1 at 200.

<sup>49</sup> P Gooderham, above n2 at 75.

to health institutions as well. Reform would not be necessary to achieved this as what the HSWA 1974 offers could respond to the need to criminalise conduct resulting in injury short of death. Offences under the HSWA 1974 offer a more appropriate criminalisation of corporate healthcare malpractice for at least two reasons: the Act specifically targets healthcare safety and it permits the criminalisation of conduct resulting in injury, and not only death.

As explained in Chapter 2, healthcare services including PCTs, Hospital Trusts, Mental Care Services and Ambulance Service Trusts are criminally liable under Section 3(1) of the HSWA 1974 for exposing their employees or other persons (patients and members of the public) to ‘risks to their health and safety’.<sup>50</sup> Allen has suggested that ‘a sensible way forward might be to prosecute Trusts for health and safety offences where the standard of health care falls *below* what can reasonably be expected, and to prosecute for manslaughter (if the common law so permits) where that standard falls *far below* reasonable expectations’.<sup>51</sup> This article was written before the CMCH 2007 was enacted. It could thus be argued that Trusts should be prosecuted for health and safety offences when the standard of care falls below what can reasonably be expected and to prosecute for corporate manslaughter under the CMCH 2007 when the institution has acted in a reckless manner ie disregarding patient safety.

I support arguments advanced by Wells and Quick on the usefulness of health and safety offences in the context of healthcare malpractice. Wells claims that health and safety offences are more appropriate than the ‘more unusual offence of manslaughter’ as they are ‘wide-ranging’ and the criteria on which the jury decides on a conviction are based on health and safety regulations and guidance.<sup>52</sup> Furthermore, there is no need to prove that any injury or death resulted from the breach of health and safety legislation although it seems that it would be easier to prosecute if death or injury had ensued. Quick notes that

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<sup>50</sup> HSWA 1974 s 2 and 3.

<sup>51</sup> N Allen, above n2 at 53.

<sup>52</sup> C Wells, above n1 at 196.

HSWA 1974 focuses ‘squarely on safety, and particularly the contribution of flawed systems’.<sup>53</sup>

Wells argues that the use of both corporate manslaughter and health and safety offences against a corporation may ‘present some problems in relation to investigation procedures, enforcement policies and of potential overlap in punishment’.<sup>54</sup> However, in January 2010 combined sentencing guidelines for corporate manslaughter and health and safety offences causing death were published.<sup>55</sup> Wells claims that ‘corporate manslaughter cases continue to look messy and are likely to give rise [...] to multiple charges in relation to the same incident’.<sup>56</sup> Thus, the way in which health institutions may be criminally liable under both the CMCH 2007 and the HSWA 1974 shows inconsistencies and lack of clear and satisfactory criminalisation of healthcare malpractice.

#### **8.4 Criminalising Health Officials and Regulators for Malpractice**

While the criminalisation of health institutions using the HSWA 1974 might sometimes be helpful to counteract healthcare malpractice, I argue that when a decision-making process in a health institution has shown disregard to patient safety at the level of recklessness, as was the case in the blood episode, the focus of criminal liability should be put on managers and regulators rather the whole institution itself. However, this approach has limits, notably due to the fact that shared decision-making may take place in this type of institutions and thus it is sometimes difficult to identify liable individuals or regulating bodies.<sup>57</sup>

It was shown that in one of England’s worst healthcare scandals between 2005 and 2009 at the Mid-Staffordshire NHS Foundation Trust, hospital staff had treated 400 to 1,200 patients with the most appalling neglect.<sup>58</sup> It appeared that

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<sup>53</sup> O Quick, ‘Patient safety and the problem and potential of law’ (2012) *Journal of Professional Negligence* 97.

<sup>54</sup> C Wells, above n1 at 193.

<sup>55</sup> Ibid.

<sup>56</sup> Ibid 194.

<sup>57</sup> P Gooderham, above n2 at 75.

<sup>58</sup> C Ellicott, ‘NHS hospital scandal left 1,200 dead could happen again, warn campaigners’, *Mail Online*, 9 November 2010.

health officials and regulators claimed that concerns had not been raised by the staff although it was later shown that concerns were raised.<sup>59</sup> Health officials and regulators had failed to prevent the neglect of these patients, which prompts the question whether criminal liability focused on health officials and regulators would have deterred this type of neglect. In the only one case so far referred to the CPS, it was found that there was insufficient evidence to prosecute.<sup>60</sup>

Merry and McCall Smith noted that ‘if the objective is to deter unsafe practices, it is very important to include within the scope of that deterrence those who actually have the authority to change those practices’.<sup>61</sup> It seems that supervisors or supervisory bodies should be held liable because they have accepted the duty to overlook lower level decisions. There should be a duty to rescue upon individual managers and managing bodies. Those who had the means to fulfil that duty, but nevertheless chose not to, should be criminally liable. They should be under a duty to check for inappropriate or late decision-making which occurred in inferior administrative bodies on a recklessness test as they could be in France for *non-assistance à personne en danger*.

A difference must be made between regulating bodies and managing bodies, and individual senior officials and managers. Managing bodies and regulators such as the CQC should lose their exemption and be held criminally liable under health and safety offences when they have failed badly on their obligations and their exclusion from criminal liability under current English criminal law should be questioned. Health officials should be punished for conduct which amounted to recklessness, when the decision-making process went against medical ethics (as for instance in the blood episode, where health officials made a priority of profit issues rather than blood safety). Investigating the decision-making process which resulted in the damage and identifying individual responsibilities seems to be the right approach to make sure that such failure does not occur again but it might be something that the English system is not apt to do at present. Minutes of

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<sup>59</sup> P Gooderham, B Toft, above n24 at 183.

<sup>60</sup> J Bingham ‘Diabetic patient died after nurses failed to give insulin injections’, *The Telegraph*, 7 September 2010.

<sup>61</sup> A Merry, A McCall Smith, *Errors, Medicine and the Law* (Cambridge University Press 2001) 214.



meetings and other administrative documents should be then investigated. In the blood episode, such investigations highlighted recklessness on the part of some health officials who had explicitly made the decision to supply contaminated blood products in their meetings.

Individual officials and managers, as much as healthcare professionals should be held to account when there was evidence that they were aware of risks to patients and chose not to act on it. The difficulty here is that unlike France, England does not recognise a duty to rescue. Thus, one lesson which we may learn from French criminal law in that area is that such a duty of care could be recognised, at least on the part of senior managers or health officials who are at the head of health institutions. The absence of such a duty has the effect of protecting senior regulators from criminal redress even in cases where they may have shown little if any regard for the safety of patients. I have claimed in Chapter 5 that *non-assistance à personne en danger* was a powerful tool against regulators and health officials.<sup>62</sup> Contrary to the criminalisation of conduct resulting in injury which might be achieved by the use of existing section 20 of the OAPA 1861 as argued in Chapter 7<sup>63</sup>, here the criminalisation of the failure to rescue must be borrowed directly from the French *non-assistance à personne en danger*.

## **8.5 Ensuring Healthcare Safety and Responding to Victims' Demands**

As explained in earlier chapters the aims of the criminal law could be considered helpful in ensuring healthcare safety and responding to victims' demands. This section aims to look at the issue of whether the criminal process is effective in ensuring that those aims are satisfied in the context of corporate healthcare malpractice.

### **Deterrence**

Although corporations do not have 'soul' or 'conscience', criminal sanctions may have an effect on them. It was argued that 'the threat of criminal sanctions

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<sup>62</sup> See Ch5, 133.

<sup>63</sup> See ch7 pt7.2.4, 207.

alone has the power to compel corporate decision-makers to abandon their exclusively economic calculus of thought and action and, for the first time, to begin to base their behaviour on a serious consideration of the human consequences of their actions'.<sup>64</sup> Might the threat of corporate punishment could have deterred CNTS officials from giving priority to finance rather than healthcare. Managers in a commercial corporation weigh the costs and benefits of the consequences of a decision so they might be deterred by the prospect of corporate punishment.<sup>65</sup> However, the threat of individual punishment would arguably have more effect on them in terms of deterrence.

Coffee argues that financial penalties against a corporation can be a deterrent.<sup>66</sup> Financial penalties would need to be sufficiently substantial to discourage the institution from taking an unjustified risk.<sup>67</sup> Quick claims that 'the fact that trusts are unable to insure against the payment of criminal fines may be an important factor in terms of helping to incentivise compliance with safety standards'.<sup>68</sup> However, the disadvantages of a fine in cases of healthcare malpractice within a publicly funded health service are its consequences on the health system. The cost of a fine will reduce the institution's income, weaken the performance of the service and result in more accidents due to reduction in staff numbers or necessary equipment for instance.<sup>69</sup> Thus, fines may not always be an appropriate sentence to deter corporate healthcare malpractice within the NHS.

Publicity may deter health institutions.<sup>70</sup> This can be illustrated by the contaminated blood case where we observed that media coverage was also perhaps a deterrent and may have been one of the reasons why health authorities decided to reform the blood system afterwards.<sup>71</sup> Wells has highlighted the limits of the CMCH 2007 in terms of deterrence. She argues that because of the time lag between the offence and the proceedings for CMCH 2007 offences,

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<sup>64</sup> R Engineer, 'Punishing Corporate Negligence, Industrial Disasters and Criminal Law' (1989) 24(14) *Economic and Political Weekly* 711.

<sup>65</sup> Ibid 713.

<sup>66</sup> JC Coffee, Jr., above n8 at 389.

<sup>67</sup> Ibid.

<sup>68</sup> O Quick, above n53 at 98.

<sup>69</sup> M Childs, 'Medical manslaughter and corporate liability' (1999) 19(3) *Legal studies* 316, 333.

<sup>70</sup> JC Coffee, Jr., above n8 at 425, 427, 433; CMV Clarkson, 'Kicking corporate bodies and damning their souls' (1996) 59(4) the *Modern Law Review* 557, 562

<sup>71</sup> See ch4.

deterrence might not be achieved.<sup>72</sup> However, some of CMCH 2007 orders could act as deterrents against health institutions. The Act provides that a court may order an organisation convicted of corporate manslaughter to publicise ‘(a) the fact that it has been convicted of the offence; (b) specified particulars of the offence; (c) the amount of any fine imposed; (d) the terms of any remedial order made’.<sup>73</sup> This type of orders of publicity could be used in association with non-criminal investigations conducted in a timely manner on the institution that I discuss later in this chapter.<sup>74</sup>

## **Rehabilitation and Incapacitation**

In terms of rehabilitating corporations, according to Clarkson, particular individuals should be ‘removed’ or ‘disciplined’.<sup>75</sup> There is no evidence that the use of the criminal law would help in ‘rehabilitating’ health institutions as such, although within the NHS, a conviction could lead to new management or transfer of functions.

The use of the criminal process against senior managers and officials might be more beneficial in terms of ensuring rehabilitation and incapacitation. But it could also lead to a situation where individuals would not want to become senior managers anymore because of their fear of the criminal law. To ensure that similar failures do not occur again in the future, review mechanisms and inquiries could be used in addition to the criminal process. The criminal process would only intervene at last resort when other means have not been effective. Even if the use of the criminal process against a health institution leads to a change in the managing team, it would come much too late. Appropriate investigations on the matter are more likely to illustrate systemic failure and poor management and investigations conducted in a timely manner would be more effective in changing things early enough.

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<sup>72</sup> C Wells, above n1 at 207.

<sup>73</sup> CMCH 2007 s10(1).

<sup>74</sup> See pt8.6.

<sup>75</sup> CMV Clarkson, above n70 at 562.

The role of the CQC may be useful here. The CQC has a capacity to prosecute health institutions for non compliance to the ‘essential standards of quality and safety’. But before it actually prosecutes an institution, it can issue a warning notice for the institution to comply promptly, restrict the services offered by the institution, stop admissions into the service, issue fixed penalty notices, suspend or cancel the service’s registration.<sup>76</sup> These measures might ensure rehabilitation/incapacitation before an actual prosecution takes place. It might also ensure prevention and safety if the institution enforces the standards of quality and safety. It would thus be more appropriate than traditional criminal liability as compliance to ‘essential standards of quality and safety’ could be achieved even before the use of the criminal process becomes necessary.

### **Prevention and Transparency**

It could be argued that the use of the criminal law could have a significant impact on the way health institutions are organised and run, and this could have beneficial consequences on healthcare safety. However, there are other mechanisms which would be more effective in terms of preventing healthcare error. This will be dealt with in the last section of the chapter.<sup>77</sup>

The contaminated blood episode illustrated the need of the victims for transparency in the healthcare context. Criminal investigations in France in part addressed this issue but were limited in evaluating systemic error. The question of whether the use of the criminal law contributed to the prevention of further healthcare accidents remains unanswered but it seems unlikely that the criminal process does much to ensure healthcare safety.<sup>78</sup> There is no evidence that the new developments in French health law following the contaminated blood scandal ie a new compensation scheme, the creation of medicine and blood agencies and the creation of the precautionary principle were principally a result of the use of criminal proceedings against health officials, doctors and ministers.

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<sup>76</sup> See <<http://www.cqc.org.uk/public/what-are-standards/standards/enforcing-standards>>.

<sup>77</sup> See pt8.6.

<sup>78</sup> J Guigue, ‘Les inconvénients de la pénalisation du droit de la santé’ (2008) *Revue de droit sanitaire et social* 36.

The use of the criminal process may have an effect in the making of preventive measures as it has been argued that politicians tend to protect themselves from criminal liability by acting on prevention, for instance, by formulating the precautionary principle.<sup>79</sup>

The CMCH 2007's provisions may help prevention in the healthcare malpractice context. The CMCH 2007 states that a court may order an organisation that has been convicted of corporate manslaughter to remedy:

(a) the breach' of a "relevant duty of care"; (b) any matter that appears to the court to have resulted from the relevant breach and to have been a cause of the death; (c) any deficiency, as regards health and safety matters, in the organisation's policies, systems or practices of which the relevant breach appears to the court to be an indication.<sup>80</sup>

The Act also indicates that 'an organisation that fails to comply with a remedial order is guilty of an offence, and liable on conviction on indictment to a fine'.<sup>81</sup> These orders are interesting and could help prevent healthcare error.

## **Retribution**

The victims' demands for seeing one person—'a scapegoat'—held liable might not be satisfied when criminalising health institutions.<sup>82</sup> Questions remain about whether families and victims would wish to know exactly who was responsible for the injury or death as individuals rather than as institutions? There have been arguments in favour of retribution as an aim for corporate liability.<sup>83</sup> And Wells

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<sup>79</sup> Interview with Dominique Marchetti (Paris, France, 17 January 2011) 7; P Rimbault, 'La responsabilité pénale des décideurs et des personnes morales', XXXIVe Congrès Français de criminologie, 14 septembre 2005, 41-42

<sup>80</sup> CMCH 2007 s9(1).

<sup>81</sup> CMCH 2007 s9(5).

<sup>82</sup> See Ch4.

<sup>83</sup> RC Ausness, 'Retribution and Deterrence: The Role of Punitive Damages in Products Liability Litigation' (1985) 74(1) *Kentucky Law Journal* 40; RA Robson, 'Crime and Punishment: Rehabilitating Retribution as a Justification for Organizational Criminal Liability' (2010) 47(1) *American Business Law Journal* 124.

argues that the CMCH 2007 might offer more by way of retribution than the HSWA 1974 which ‘aims at minimising risk directly’.<sup>84</sup> However, as stated earlier, the CMCH 2007 excludes a large number of cases where health institutions could be held liable. Thus, retribution is unlikely to be met if the CMCH 2007 is used. Prosecutions against senior managers would be more likely to succeed as it would be easier to prove mens rea on the part of an individual than on the part of an institution. Moreover, in reality, the penalties likely to be imposed against corporations will not be seen as a sufficient response to the wrong that has been done. Thus, the criminalisation of individuals is more likely to provide retribution.

## 8.6 Alternatives to the Criminal Process

This section aims to discuss very briefly more appropriate ways in which corporate healthcare malpractice/error can be dealt with which would rightly and promptly engage to promote patient safety in the healthcare system.

French criminal procedure provides in-depth investigations and help to identify responsible individuals. However, I have also demonstrated that such criminal investigations often fail to identify systemic failure. Systemic failures in the healthcare context should be investigated by effective and open inquiries which could issue recommendations and act before the criminal process is invoked. These may be particularly relevant in cases where the failure was a result of the whole system. Experts could identify systemic failures and their causes taking into consideration surrounding circumstances and events. This would benefit the healthcare system as it would also help to prevent future failures and suggest ways of reducing error.<sup>85</sup>

In Chapter 3, I described the role of *pôles de santé publique* in France in cases of systemic healthcare malpractice.<sup>86</sup> *Pôles de santé publique* could respond to the shortcomings of having non-medical specialists (CPS and the police) analysing

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<sup>84</sup> C Wells, above n1 at 207.

<sup>85</sup> M Childs, above n69, 337.

<sup>86</sup> See ch3 pt3.4.1, 71.

healthcare malpractice cases, as well as having one specialised body in charge of healthcare malpractice resulting from systems error. Their features could thus be used in non-criminal proceedings to ensure transparency and prevention of systemic failure. Coroners in England may analyse systemic failure but this only occurs when death has ensued and thus excludes cases where the failure resulted in injury.

Prevention should be the first means to reduce healthcare accidents and malpractice. In France, the precautionary principle led to the creation of agencies in charge of preserving safety in health institutions. They offer risk assessment and expert reports on adverse events in health institutions.<sup>87</sup> Gobert argues that corporations should establish ‘monitoring and review mechanisms’ to check that policies are implemented properly.<sup>88</sup> Monitoring and review mechanisms such as morbidity and mortality reports might also be an efficient alternative to criminal investigations. One of the drawbacks of criminal law is that it only recognises events which come to light.<sup>89</sup> However, monitoring and review mechanisms may overcome that issue by acting upstream before the use of the criminal process becomes necessary.

## 8.7 Conclusion

This chapter aimed to discuss whether the criminalisation of corporate healthcare malpractice is an appropriate way to deal with healthcare malpractice. As argued in previous chapter regarding individual healthcare malpractice, the criminal law should only be used to punish morally wrongful conduct which amounts to recklessness committed by health institutions or managers. We should not follow the criminalisation of health institutions for simple negligence observed in France. For reasons of both principle and pragmatism, the CMCH 2007 is not the right answer to corporate healthcare malpractice as some have thought.

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<sup>87</sup> JF burgelin, ‘La médecine saisie par le principe de précaution’ (2000) 184(5) *Bulletin de l’Académie Nationale de Médecine* 873, 898.

<sup>88</sup> J Gobert, above n14 at 397.

<sup>89</sup> A Merry, ‘How does the law recognize and deal with medical errors?’ (2009) 102 *Journal of the Royal Society of Medicine* 265, 268.

Corporate conduct resulting in injury should be criminalised in England. The use of corporate manslaughter under the CMCH 2007 is thus not sufficient to ensure that criminal liability does not only depend on outcome and admits too many exceptions where health institutions could have shown a level of recklessness which should be punished. The HSWA 1974 on the other hand could achieve that aim but recklessness is not required. Whenever individual culpability can be found on the part of senior managers, individual criminal liability should be used. In other cases, notably in cases of systemic failure, current criminal liability under the CMCH 2007 is not appropriate. Rather offences under the HSWA 1974 should be used to counteract corporate malpractice and the focus should be put on senior managers or officials and managing or regulating bodies.

However, some of the CMCH 2007 orders could act as deterrents and ensure prevention in health institutions. Such orders could be used alternatively without resorting to the criminal process. Measures of compliance taken by the CQC when a health institution does not meet essential standards of safety could also contribute to preserving healthcare safety. I suggested that investigation processes (including in the most serious cases, public inquiries), monitoring reviews and the use of preventive mechanisms should be used in first resort to avoid using the criminal process for problems which could be solved more effectively and more quickly by the use of these mechanisms.



## **9. Conclusion**

Within this thesis, I sought to contribute to a better understanding both of why the French criminal process more readily addresses cases of healthcare malpractice than is the case in England and how far a study of the different ways in which the criminal process relates to medicine in those two countries assists evaluations of the role that the criminal process should play in relation to injury and death in a healthcare setting. Should England adopt any part of the model offered by French law and procedure in relation to holding health professionals, managers and institutions to account for healthcare malpractice? In asking that question, I have addressed both what might be seen as the usual cases of healthcare negligence and breach of duty by doctors and hospitals and catastrophic failure in the delivery of national health services as illustrated by the contaminated blood episodes.

This thesis engages in recent debates about the role of the criminal process in regulating and responding to healthcare malpractice. In particular, the study follows on from the critical analysis undertaken by Merry and McCall Smith on the usefulness of legal responses in dealing with healthcare malpractice. Central to the debate is the question of whether the criminal process is usually designed to punish morally wrongful conduct. This thesis does not deal with this immense and general issue of criminal law theory but focuses very specifically on the role of the criminal process in healthcare malpractice cases which differ from many other cases of negligence in their complexity, the difficulty to establish causation and potential impact on patient safety. The gross negligence manslaughter test in England renders issues relating to proving negligence even more difficult and the reliance on experts even more significant. The findings from this study make several contributions to the current literature by focusing on a comparative analysis between the role of the criminal process in France, a civil law jurisdiction, and England, a common law jurisdiction, and by analysing the usefulness of the criminal response to the HIV-contaminated blood episode.

## Explaining Differences

This research has found that features of criminal procedure play an even more considerable role than substantive criminal law in the criminalisation of healthcare malpractice. Differences in substantive laws do nonetheless have a role to play. Coming from two different legal traditions, France and England, have different perspectives on criminalising healthcare malpractice. French criminal law provides for a more general criminalisation of negligence which includes a larger range of negligent conduct, from simple negligence to recklessness, as well as conduct resulting in injury short of death and the failure to rescue someone in danger. Thus, there is greater scope to prosecute for harms caused by malpractice on the part of doctors and officials. On the other hand, only gross negligence resulting in death is usually the subject of criminal charges in the healthcare malpractice context in England. It was noted that non-fatal offences are in principle to be found in English criminal law to prosecute cases of healthcare malpractice which resulted in harm short of death. These offences are nevertheless not currently used generally to prosecute doctors for malpractice.

Procedural differences have an even more significant impact than substantive law on the use of the criminal process in healthcare malpractice cases. Two main procedural factors are responsible for the greater use of the criminal process in the healthcare malpractice context in France. The right of victims to be *parties civiles* and launch criminal proceedings against doctors explains why many cases of healthcare malpractice are prosecuted in France while many similar cases in England are not. Furthermore, the French inquisitorial system of procedure provides for in-depth pre-trial investigations conducted by a single *juge d'instruction* which is often in favour of responding to victims' demands for prosecuting doctors. This research has shown that *juges d'instruction* have a significant role in pushing the *Ministère Public* to prosecute doctors for malpractice. On this side of the Channel, victims cannot launch criminal proceedings against healthcare practitioners and the Crown Prosecution Service in England is rather reluctant to prosecute doctors.

The examination of the use of the criminal law in the HIV-contaminated blood episode in France and England in Chapters 4-6 revealed that substantive and more

importantly procedural factors, were determinant in the use of the criminal process in the episode and confirmed findings arising in the first two chapters. The impact of *juges d'instruction* and *parties civiles* on the use of the criminal process in the episode was significant and helps explain why so many criminal proceedings were launched in France and none in England following a similar healthcare disaster. This research has noted that unlike most other cases of healthcare malpractice, the media and the public had a major impact on the use of the criminal process in the episode. The use of the criminal process did not however respond to the episode as well as victims or the public would have hoped, yet also created outrage amongst the medical profession. While the criminal process was limited in ensuring deterrence and prevention in response to the blood scandal, investigations conducted by *juges d'instruction* did provide with some kind of transparency and closure and it was found that the criminal process was the only process that could provide retribution, and retribution was often a major concern of the victims who felt betrayed by the health service on both sides of the Channel.

### **Lessons from France**

The present study provides additional evidence to agree with Merry and McCall Smith that to a large extent, the general aims and functions of the criminal law are not achieved by its use in cases of healthcare malpractice, especially in cases where no moral culpability could be proven. Key lessons to be drawn from the present study are that criminal law does not respond to healthcare malpractice as effectively as other processes would, and should be limited to morally wrongful conduct which reached the level of recklessness. The French model of criminalisation of simple negligence should not be followed. However, the study of French criminal law in the healthcare malpractice context indicates that certain reforms of English criminal law and/or prosecution policy are needed. There is at present too great a scope for moral luck in criminal liability for healthcare malpractice, and reckless conduct resulting in non-fatal injury should be criminalised to allow prosecutions of doctors whose disregard for their welfare has caused injury to patients. New legislation is not necessarily required as section 20 of the Offences against the Person Act 1861 'causing grievous bodily harm' could and should be used to achieve this.

The criminalisation of corporate healthcare malpractice should also be limited to morally wrongful conduct and rather than too great a focus on corporate responsibility, the criminal process should particularly target senior managers and regulators who have recklessly failed on their obligations, endangering the patients and the whole system for the delivery of healthcare. The use of a form of the Good Samaritan law borrowed from the French *non-assistance à personne en danger* could be used to achieve this but a general duty to rescue would have to be recognised in English law to hold managers and regulators criminally liable for their failures as is the case in France .

### **Improving Responses to Healthcare Malpractice**

The findings of the present study suggest a role for selective features of French criminal procedure in promoting healthcare safety and responding to victims' demands but used outside the scope of the criminal process. The role of the *juge d'instruction* in the healthcare context has demonstrated the need for thorough investigations on healthcare malpractice cases to ensure transparency and closure to victims. This could be addressed by investigation processes, including in the most serious cases public inquiries, with substantial means of investigation and the power to issue orders of compliance for health institutions to act promptly and eliminate factors which caused systemic failure. The role of *parties civiles* in France has demonstrated the importance of the involvement of victims in procedures involving negligent healthcare professionals and the need for providing victims of healthcare accidents appropriate compensation. Further work needs to be done to establish whether no-fault compensation schemes could respond to victims' demands for closure and compensation as well as providing speedier compensation more cost effectively. The criminal process is not an appropriate way to learn from our mistakes and ensure safety. There is a need to improve preventive mechanisms and ensure that healthcare failure does not recur in the future. In an era where healthcare accidents come more and more to light and affect more and more patients, effective solutions need to be found. The criminal process should still have a role but one limited to the cases where a doctor, official or an institution has acted in a manner

that demonstrates a lack of regard for the safety of patients and/or endangered patients unjustifiably for no acceptable reason.

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Annexe 9 : R Netter (Laboratoire National de la Santé) Note pour Monsieur le Directeur General de la Santé, 27 février 1985 (arrivé le 28).

Annexe 10 : R Netter (LNS) Note pour Monsieur le Professeur Roux Directeur Général de la Santé, 14 Mars 1985 (arrivé le 15).

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Annexe 16 : M Garetta (Centre national de transfusion sanguine), Lettre confidentielle à Mme Pierre (Ministère des affaires sociales et de la solidarité nationale), 9 mai 1985.

Annexe 17 : Secrétariat général du gouvernement, Compte-rendu de la réunion interministérielle tenue le 9 mai 1985 sous la présidence de M. Gros (confidentiel), conseiller auprès du Premier Ministre, 17 mai 1985 (diffusé le 22).

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## **Interviews**

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Interview with Marie-Odile Bertella-Geffroy (Paris, France, 18 January 2011)

Interview with Dominique Marchetti (Paris, France, 17 January 2011)

## **Other**

Statistics from the *Ordre des Médecins* (sent via email)

## **APPENDIX**

### **Appendix 1**

Interview transcripts (Interview with Dr Marchetti, Interview with A)

The transcript of the interview with Marie-Odile Bertella-Geffroy is not appended as in addition to materials that the judge authorised me to cite and quote in the thesis, it contains background information supplied on a confidential basis.

### **Appendix 2**

*Ordre des médecins* statistics (2007/2010)

### **Appendix 3**

M Kazarian, D Griffiths, M Brazier, 'Criminal responsibility for medical malpractice in France' (2011) 27(4) *Journal of Professional Negligence* 188

### **Appendix 4**

AM Farrell, M Kazarian, 'The role of the criminal law in healthcare malpractice in France: examining the HIV blood contamination scandal' in D Griffiths, A Sanders (eds), *Medicine, Crime and Society* (Cambridge University Press Forthcoming 2013)

**DR DOMINIQUE MARCHETTI**

**17 JANVIER 2011**

**A = Mélinée Kazarian**

**B = Dominique Marchetti**

**C = Anne-Maree Farrell**

A - Donc en fait, on fait partie d'un projet qui travaille sur le rôle du droit pénal dans la santé, donc il y a des chercheurs, des professeurs et il y a deux étudiants donc qui travaillent sur le rôle du droit pénal dans la santé et qui font une étude comparative en fait entre des pays étrangers et l'Angleterre.

B - D'accord

A - Donc moi je fais sur la France et l'Angleterre, l'autre étudiante fait sur la Hollande et l'Angleterre sur l'euthanasie et donc on va faire des publications sur le sujet, on va écrire des livres et on va écrire deux thèses

B - Et donc c'est en droit, vous faites des thèses de droit ?

A- En fait, oui, les deux thèses c'est du droit, mais il y a aussi des spécialistes de l'éthique qui travaillent sur le sujet....

B - Oui

A - Sociologie, droit, c'est interdisciplinaire

A - Donc pouvez vous nous donner votre nom complet et si vous pensez faire l'interview et l'enregistrer ensuite ?

B- Donc je m'appelle Dominique Marchetti et je consens à cette interview et à sa reproduction.

A – Merci.

A - Que faites-vous actuellement ?

B - Je suis chercheur en sociologie au Centre National de la Recherche Scientifique (CNRS). Voilà.

A - Et comment vous êtes vous retrouvé à faire de la recherche sur l'affaire du sang contaminé ?

B – j'étais en...l'équivalent de deuxième année de Master....en Science Politique à l'Université de Paris I Sorbonne et je travaillais avec Patrick Champagne qui est un des anciens collaborateurs de Pierre Bourdieu et je travaillais sur les médias et je voulais travailler sur le fonctionnement des médias en France...des médias d'information générale et politique et de grande diffusion, et je cherchais à traiter un événement...heu...en train d'émerger. Et...dans mon début de recherche c'était en



1992...j'ai....je suis....enfin 1991-1992....je me suis intéressé à l'affaire du sang contaminé comme ça parce qu'elle commençait à prendre. Et ce qui m'avait intéressé...à l'époque, c'est qu'il y avait une dimension...comment fonctionnent les médias et une autre dimension qui était...comment se construit un événement...Et là ce qui était intéressant, c'est que, au moment des faits dans les années 1980, c'était perçu comme un drame par les médias et l'intérêt était de comprendre comment c'était devenu un scandale. Donc une partie de mon travail de DEA, ça a été de chercher un peu historiquement comment on était passé du drame au scandale et comment émergeait un scandale, c'est devenu aussi une sociologie du scandale. Voilà, c'est un peu le cadre, et je travaillais avec Patrick Champagne qui lui était un spécialiste des médias, l'analyse des manifestations notamment. Voilà, c'est comme cela que je me suis intéressé à cette affaire et j'ai ensuite prolongé un petit peu ce travail pour une étude pour le Conseil National du Sida qui est un Comité d'éthique français qui, à l'époque, était intéressé par mon travail. Et donc j'ai prolongé un petit peu, ensuite je suis parti au service militaire et j'ai fait une thèse, j'ai continué la thèse sur le sujet...toujours avec l'idée de comprendre le fonctionnement des médias mais j'essaye de comparer...le scandale du sang contaminé à d'autres scandales concernant le SIDA dans les années 1980.

A – Ok

B- Je suis revenu un peu plus dans l'histoire....enfin l'histoire courte mais voilà un peu grosso modo mon parcours et donc j'ai fait une thèse de sociologie à l'École des Hautes Études en Sciences Sociales sous la direction de Patrick Champagne et de Pierre Bourdieu.....voilà.

A – En fait ma question, mais je crois que vous avez déjà répondu, pouvez vous décrire votre recherche, sur le sang contaminé et ce que vous avez trouvé ?

B – Alors, ce que j'ai trouvé....en fait j'insiste, le scandale du sang contaminé c'était pour moi une manière de travailler sur le fonctionnement des médias et...au départ je ne m'étais pas intéressé plus particulièrement à ce cas là. Ce que j'ai trouvé...ça tient...ça demanderait beaucoup de...je ne sais pas....ce que vous attendez exactement de...dans les résultats, dans les....

A – En général en fait.

B – Moi ce qui m'a intéressé, c'est ce qu'on appelle en France mais aussi en Anglais la construction publique du problème, c'est-à-dire voir comment évoluent les perceptions publiques d'un problème et donc ça je trouve que c'est un vrai apport du travail c'est-à-dire de montrer...et c'est pour ça que mon travail avec Patrick a aussi été parfois critiqué...parce qu'il remettait le scandale du sang contaminé, les faits dans un contexte général et je pense que ça ne faisait pas plaisir aux journalistes parce que je montrais qu'à l'époque la plupart des choses étaient dans la presse. Sauf que quelques années après, la perception de ces choses a changé. Ou qu'on relisait d'une certaine manière ce qui se disait à l'époque. Ce que je dis là, ça ne veut pas dire que je défends les accusés, même si parfois malheureusement, quand on travaille sur ce sujet-là, souvent les gens vous classent dans un camp ou dans un autre. Ils ne comprennent pas la démarche sociologique un peu compréhensive. Mais ça c'est la première chose, essayé d'avoir montré qu'à l'époque, tous les éléments n'étaient pas réunis pour qu'il y ait un scandale. Et c'est qu' ensuite, qu'un certain nombre d'éléments, et notamment le fait qu'il y ait eu une conjoncture politique spécifique, le fait que il y ait des gens qui avaient des révélations à faire et qui avaient des comptes à régler avec d'autres médecins... et ce qui est intéressant je trouve dans cette affaire, c'est qu'à un

moment donné, au début des années 1990, dans différents univers, se sont cristallisés des conflits et moi ce que j'ai essayé de montrer comment au début des années 1990 le scandale du sang contaminé à émergé aussi parce que se sont cristallisés des conflits entre journalistes qui, à l'époque, ont traité de l'affaire mais différemment d'aujourd'hui et donc, du coup, de montrer que les conflits de l'univers du SIDA, les conflits de l'univers journalistique ont contribué à ce moment-là à faire émerger ce scandale et à devenir très rapidement une affaire politique, puisque vous le savez qu'en France tout ce qui est traité autour de la transfusion est en lien direct avec l'État, donc avec le politique, c'est ça aussi. Donc ça c'est la première chose, la deuxième chose, sur laquelle j'ai beaucoup travaillé, là peut être que ça vous intéresse moins, c'est de montrer comment fonctionnait l'univers médiatique et comment aussi si ce scandale avait eu autant d'impact, c'est parce que l'on est dans des années où les chaînes de télévision commencent à prendre le pouvoir dans l'information et parce que l'on peut montrer les malades, parce que la télévision a un impact beaucoup plus grand qu'autrefois où elle existait si vous voulez mais elle ne faisait que reprendre la presse écrite. Il y a ça et ce que j'ai essayé aussi de montrer avec Patrick, ce sont les transformations du journalisme médical et comment on est passé par une information très contrôlée par des journalistes médicaux à une information de santé grand public qui fait intervenir différents types de journalistes, et donc comment la santé est devenue médiatique. Vous pourrez trouver, j'ai sorti un livre il y a huit ou neuf mois sur le sujet en fait, tiré de ma thèse et je peux vous donner la référence si ça vous intéresse. Malheureusement après je n'ai pas pu beaucoup traiter ce sujet là mais j'aurais aimé le faire davantage. C'est quels sont les liens entre l'univers journalistique avec l'univers judiciaire, avec l'univers politique etc.....et une des choses que l'on a réussi à montrer, c'est comment le fait que les médias s'emparent du sujet cela fait monter les critères d'opinion, les critères d'audience etc. Et donc des critères d'opinion, des critères moraux interviennent sur la perception de la justice, des décisions de justice etc....pour aller vite, comment les médias instaurent une justice 'concurrente' de celle de la justice française parce qu'il y a eu quand même pas mal de débats autour de ça. Je ne sais pas si ça répond à vos questions.

A - En fait, ça fait partie des questions suivantes. En fait la question suivante c'est qu'il y a eu des changements dans les médias français dans le début des années 1980 et est ce que c'est ça qui a eu un impact sur la façon dont les médias ont fait le portrait de l'affaire du sang contaminé ?

B – Oui, enfin quand je dis ça, parfois on a été caricaturé et on me faisait dire que les médias ont construit un scandale. D'abord ils ne se construisent pas tout seuls et ça ne veut pas dire qu'ils partent de rien, il y a des faits, tout ça, mais simplement, le fait que la télévision ait prit autant d'importance à ce moment-là...il faudrait revenir dans le temps mais si on compare avec des affaires des années 1980...c'est plutôt la radio qui était importante dans l'univers médiatique. La radio est beaucoup plus importante car la télévision ne fait pas encore des directs au milieu des années 1980 par exemple il y a un livre d'un journaliste sur ce que l'on appelle « L'affaire du petit Gregory ». C'est Laurence Lacour que vous avez peut être rencontrée d'ailleurs qui travaille aussi sur le sang contaminé, mais de façon plus journalistique, elle est dans le documentaire, vous verrez. C'est une journaliste qui est devenue écrivain en fait. Et ce qui est intéressant par exemple, elle montre comment émerge cette affaire d'un gamin qui est assassiné etc....mais ce qui est intéressant dans son livre c'est qu'on voit que c'est la radio à l'époque qui occupe une position déterminante. Et quelques années après, on revient aussi, même si internet redessine probablement les rapports de force, mais que la télévision prend....et donc là, le fait que la télévision....ce qu'elle ne faisait pas avant....montre des malades atteints...les propriétés de ces malades, le fait que ce

soit des enfants...que l'on voit surtout des enfants et des mères de famille en fait, ça a un impact très fort sur le traitement du sujet, c'est-à-dire que, très vite, et c'est ce que j'essaye de montrer dans la fin de mon livre, ça répond beaucoup aux logiques commerciales des médias et on individualise la question du sang contaminé en montrant des malades...Certains journalistes pensent que ça permet une identification forte possible avec le public et, pour aller vite là encore, on pourrait dire que c'est un scandale tout particulièrement fait pour la télévision....parce qu'on a des cas que l'on peut montrer et, en plus, ce sont des enfants. Et donc, d'un côté on a cet État qui est critiqué, les politiques etc....et, d'un autre côté, ces pauvres enfants, enfin voilà....et j'ai essayé de montrer comment ces mécanismes, ça n'atteint pas uniquement la télévision mais ça atteint aussi la presse écrite. La presse écrite va aussi faire beaucoup de sujets là dessus. J'ai essayé de montrer que, selon le type de médias, il y a différents types de sujets mais que, globalement, le média dominant, c'est la télévision et que la vision dominante sur ce scandale, c'est une vision assez simple, qui consiste à dire : voilà, il y a la faute de quelques politiques, de quelques scientifiques, qui ont tué sciemment des enfants. C'est quand même la vision dominante de cette affaire à travers les medias audiovisuels. C'est ce que j'essaye d'expliquer dans le travail de thèse. Je ne sais pas si je dois vous l'envoyer. Je peux vous envoyer ma thèse si vous voulez.

A – Ok

B – Où j'essaye de montrer les différences qu'il y a dans la vision de l'affaire entre les journalistes, parce que tous n'ont pas la même vision et, la vision qui domine, c'est l'accusation du Docteur Garetta, du CNTS, des politiques, et comment il y a des combats journalistiques autour de ça. Mais c'est vrai que vous avez raison, le poids de la télévision, vous voyez si aujourd'hui il fallait faire la même enquête, si ça se passait aujourd'hui, je pense qu'il faudrait intégrer internet et aussi beaucoup plus qu'à l'époque, les chaînes de télévision d'information en continu qui, à l'époque en France, commençaient mais n'avaient pas beaucoup d'impact. Mais aujourd'hui, il faudrait avoir l'équivalent, vous savez bien en Angleterre que ces medias, Sky News....BBC 24, et en fait ce ne sont pas des chaînes, comment dire, très regardées mais elles sont beaucoup regardées par les journalistes. Donc elles ont de l'importance dans le traitement de l'information. L'idée, c'est que c'est coproduit par les médias et de montrer aussi comment quand ça arrive dans l'univers médiatique, cette affaire, enfin je veux dire la vision est un peu simplifiée et transformée, individualisée, et psychologisée etc....enfin tous les mécanismes qu'ont décrit les chercheurs, un peu structuraux qui expliquent cette affaire qui est quand même très compliquée là dans les médias, sauf quelques papiers par ci par là, c'est pas ça qui domine, c'est une problématique très individualisante, avec des causalités très directes. Et si peut être, excusez-moi, c'est peut être une future question mais, ce que l'on a essayé de faire, c'est de montrer l'impact des médias sur...je pense que c'est quand même assez rare une affaire qui a autant d'effet sur les politiques publiques de santé, c'est-à-dire qu'à partir du moment où cette affaire a émergé, s'est construite, etc....ça a eu quand même, on a changé la transfusion, on a créé des agences sanitaires et ça a eu énormément d'impact à la fois sur la justice, vous êtes mieux placés que moi pour le savoir, mais aussi sur le fonctionnement de la santé publique en France. En tout cas, symboliquement, ça a eu des effets. Cette affaire a eu des effets importants et d'où l'émergence de ce que l'on applique en français le principe de précaution etc....et c'est quand même une dimension, et je pense que les médias ont contribué mais pas à eux seuls, et ça a eu des effets, peut être non pas sur la population car c'est impossible à mesurer mais, comme les medias sont très importants dans l'univers politique, ça a

eu des effets sur l'univers politique et son fonctionnement. Je réponds peut être à plusieurs questions en même temps.

A – Oui.

B – Mais dites-moi si je réponds trop longuement.

A – Non

A – Est-ce que vous pensez que les médias ont eu un impact sur la pénalisation de l'affaire et de la vie publique en général ?

B – Alors ca c'est un peu...ils ont essayé d'avoir un impact, et c'est pour cela qu'il y a eu une différence entre la justice qui était rendue dans les medias et la justice qui était rendue dans les prétoires. C'est-à-dire que, par exemple, le premier procès, le plus flagrant c'était à la limite pour les politiques, parce que, dans un premier temps, les journalistes qui connaissent très peu le droit, ils ont très peu de connaissances dans le droit, sauf ceux qui suivent les procès, c'est ce que j'essaye de montrer dans mon travail. Et donc, lors du premier procès, ils ne comprennent pas pourquoi il y a si peu de monde qui est condamné ou dans le prétoire. La deuxième chose, c'est qu'ils ne comprennent pas aussi que les politiques ne soient pas directement accusés. Ce qui est impossible car les ministres relèvent d'une autre juridiction etc....Et ce qui m'a frappé, c'est qu'un bon nombre de journalistes a essayé de pénaliser l'affaire effectivement, et notamment en lien avec les associations de malades qui avaient des vues très divergentes. Il y avait ceux qui préféraient rester sur la loi de 1905... le premier procès en disant, c'est bon...et ceux qui voulaient aller jusqu'à l'empoisonnement. Donc voilà. Et donc ça, c'étaient les associations de malades, j'allais dire les plus récentes souvent, et soutenues par un certain nombre de journalistes qui eux aussi voulaient pénaliser l'affaire. Et il y avait un autre groupe de journalistes qui voulaient la politiser. C'est une autre façon de pénaliser aussi, et donc voilà, c'est pour cela que l'on est arrivé jusqu'au politique. Mais enfin, on peut dire....je ne sais pas s'ils ont pénalisé mais il y avait une volonté...clairement une perception dominante que la justice n'était pas rendue dans les tribunaux et qu'il fallait la rendre...et que ca passait beaucoup par les journalistes, c'est-à-dire y compris les associations...(...) essayent comme elles n'arrivent pas à agir sur la justice...essayent de recourir aux médias pour pénaliser les infractions....et donc recourent à des avocats médiatiques...ca c'est très frappant, la pénalisation et la politisation de l'affaire...ce ne sont pas les médias en soit, mais....ils y ont contribué et ceux qui y ont le plus contribué, ce sont ceux qui ne connaissent pas les mécanismes judiciaires... C'est-à-dire que moi je me souviens dans mes entretiens, il y avait des vraies différences entre la perception des journalistes j'allais dire scientifiques, médecins, des journalistes qui avaient l'habitude de traiter de la politique, des informations générales, c'est-à-dire du tout venant, qui étaient eux plus pour politisation, pénalisation etc. et, de l'autre côté, des journalistes judiciaires suivent les procès, et qui eux connaissent plus le fonctionnement de l'univers judiciaire, qui étaient surpris. Quand ils ont suivis le premier procès, ils ont compris plein de choses, ils ont vu la différence entre ce qu'ils avaient lus dans les journaux et ce qu'eux avaient vus dans le tribunal. Voilà. Et là je pense qu'il faut faire une différence entre les différents types de journalistes. Parce qu'ils n'ont pas du tout la même vision, mais c'est vrai que la vision dominante c'était de politiser et de pénaliser l'affaire. Avec des mécanismes bien connus qu'à décrit Hoggart...hein...il y a le « eux » et le « nous »...hein...c'est-à-dire que c'est les élites contre...hein...voilà....enfin c'était quand même beaucoup vu sous cette manière là. On peut dire qu'ils ont contribué à la politisation, à la pénalisation de l'affaire, mais encore une fois, j'allais dire, tout le monde y a

contribué....les associations, certains avocats aussi... Mais ce qui est intéressant dans cette histoire, c'est que dans les années 1980, 1990, quand il y avait un problème judiciaire, c'est-à-dire que les familles de victimes n'arrivaient pas à obtenir ce qu'ils voulaient auprès de la justice, ils sont allés voir les médias pour défendre leur cause...et l'empoisonnement est passé par là d'ailleurs, c'est par un biais médiatique. Je me souviens, j'essaye aussi de l'expliquer dans ma thèse, comment à l'automne 1991 on essaye de passer à l'empoisonnement quoi : via des avocats, une avocate médiatique, qui a une association qui est dirigée par quelqu'un qui connaît bien les médias. Enfin voilà quoi. Moi ce qui m'a intéressé, c'est le décalage entre ce qui se joue du côté des médias et de la perception qu'ils ont de la justice de cette affaire là et ce qui s'est joué dans les prétoires qui était différente quoi. C'est tout. J'essaye de parler doucement mais je ne sais pas si c'est très facile de comprendre.

C – Mais c'est très facile.

A – Pensez-vous que l'utilisation du droit pénal a eu un résultat juste et équitable pour les accusés ou les mis en examens et pour les victimes de la contamination ?

B – Moi ce n'est pas mon rôle de répondre à ce genre de questions, je suis un chercheur, donc je ne sais pas si... en tout cas, la conclusion c'est que ça n'a pas été compris. C'est-à-dire que les règles de la justice n'ont pas été comprises, et notamment par les différents protagonistes et qu'il y avait un décalage entre la manière dont la justice a traité de ce problème là et la manière dont les associations de victimes et aussi les médecins et aussi les politiques ont vu le fonctionnement du droit pénal. Ca c'est très clair. Tout le monde c'est mis à critiquer la justice et à dire que les règles n'étaient pas les bonnes. Après moi, je n'ai pas à dire si ça a bien fonctionné ou si ça a mal fonctionné, moi tout ce que je constate, c'est que quand même il y a un vrai décalage entre ce qu'a fait la justice, qui a quand même beaucoup participé à la compréhension de cette affaire mine de rien et à faire un travail assez énorme de compréhension du fonctionnement de l'État....enfin je ne sais pas si vous avez eu accès à....enfin moi j'ai assisté au procès des trois anciens Ministres....enfin c'était quand même très intéressant, c'est-à-dire que l'on comprenait le fonctionnement de la décision politique, on apprenait quand même que....enfin ça entraînait beaucoup dans le détail....bien sur la population, les chroniques judiciaires...portaient peu la dessus mais c'était quand même très intéressant d'un point de vue de compréhension de l'affaire. Mais tous les protagonistes que j'ai interrogé, que ce soit des journalistes, que ce soit des avocats, que ce soit des médecins qui étaient aux premières loges, que ce soit des politiques, tous ont eu a critiqué très fortement le fonctionnement de l'appareil judiciaire sur cette affaire pour différentes raisons. Mais voilà, c'est très clair, mais après, est-ce que c'est bien ? Est-ce que c'est mal ? En tout cas ça n'a pas été compris je pense par l'ensemble des acteurs. Mais je veux dire, est ce que ce n'est pas normal aussi, Là, voilà, c'est une affaire tellement compliquée, à analyser. Si vous voulez, juste pour vous citer un exemple, vous pouviez faire un entretien a deux jours d'écart, vous pouviez rencontrer quelqu'un qui était sur le banc des accusés et une journaliste qui elle accusait cette personne et tous les deux avaient des visions mais tellement opposées de l'affaire que je veux dire je ne vois pas pourquoi je douterais de leur bonne fois mais tous les deux critiquaient très fortement la justice. Je ne sais pas moi qui est-ce que vous avez vu ? Vous rencontrez des magistrats ?

A – Demain on va voir Marie-Odile Bertella-Geffroy je crois.

B – À oui, d'accord.

A – Mais bon, on n'a pas eu d'autres réponses en fait.

B – Ah dommage. Moi je connais plutôt celle qui a fait le premier...Madame Foulon et Madame Bernard Requin. Elle n'a pas répondu Madame Bernard Requin ? Vous n'avez pas essayé ?

A – Je n'ai pas trouvé.

B – Ce n'est pas facile à trouver en fait. Mais voilà, il y a une insatisfaction par rapport au traitement judiciaire de l'affaire, ça c'est...c'est très clair.

C – Pour les victimes ?

B- Pour les victimes, mais aussi pour les médecins et pour les politiques aussi, parce qu'ils s'estimaient accusés à tort. Très concrètement. Ils s'estimaient victimes d'une injustice, eux aussi. Enfin c'est une affaire vraiment intéressante à étudier aussi vraiment d'un point de vue justement de sociologie du droit, c'est-à-dire comment....enfin moi je n'ai pas pu le faire, je ne suis pas un spécialiste.....mais comment le droit traite d'une question de santé publique aussi compliquée. C'est passionnant. Et la rencontre entre cet univers de scientifiques qui n'a pas du tout l'habitude d'être contesté, mis en question etc....et puis aussi bon voilà, des gendarmes qui les maltrahaient. Enfin bon....Ca a donné lieu à des confrontations très, très violentes. Très, très violentes, pas physiquement mais verbalement j'en ai eu des échos...C'étaient des rencontres entre deux mondes, bon voilà, deux mondes du savoir et qui a été très violent. Et qui a été très mal vécu, très, très mal vécu.

A – Sur le long terme, vous pensez que c'est bien d'utiliser le droit dans le domaine de la santé, pour le principe de précaution ?

B - Je suis gêné de donner une appréciation normative. J'étudie le fonctionnement, je ne peux pas dire si c'est bien ou c'est mal. Ca ce n'est pas mon rôle de chercheur. Mais en tout cas je suis persuadé que ça a fait progresser le droit sur ces questions là. Puisque ça a posé des questions nouvelles non seulement à la santé publique mais aussi au droit. Et donc voilà, ce dont...si je peux me permettre quelque chose de plus personnel mais c'est vrai que j'ai l'impression que, comme dit mon collègue Patrick Champagne : « Je me demande si aujourd'hui le principe de précaution ce n'est pas le principe de précaution pour les élites », c'est-à-dire est ce que c'est la protection de la population ou plutôt comment les élites se protègent pour éviter...hein....on se demande. Et les médecins, pour le coup, les médecins, ça a eu des conséquences énormes. Ils prennent maintenant, ils signent des assurances.

C – Et c'est bon ou mauvais pour les médecins et pour les politiques ?

B – Je n'ai pas travaillé sur la question, je ne sais pas si ça a des effets positifs, des effets négatifs. Mais en tout cas, maintenant, quand ils prennent des décisions, je pense qu'ils se protègent juridiquement, beaucoup plus fortement qu'avant car avant ils ne se sentaient pas inquiétés. Mais j'en suis persuadé, maintenant c'est très clair.

A – C'est plus au niveau de la protection mais ça n'a pas fait de changement dans la manière dont ils prennent les décisions tout ça ?

B – Je n’ai pas travaillé à la question, je ne suis pas compétent sur le sujet. Je ne me permettrais pas de...Mais en tout cas, ce que montre cette affaire, c’est que de toute façon, ils prenaient beaucoup en compte ce que disaient les medias, voila, mais maintenant ils prennent aussi en compte les éventuelles poursuites judiciaires auxquelles ils pourraient être confrontés. C’est quand même la nouveauté avec cette affaire-là. C’est la première fois en France en tout cas qu’ils sont inquiétés de cette manière-là. Et encore une fois, vous le savez bien, les gens des cabinets politiques, des cabinets des ministres, tout est lié à l’État dans cette affaire-là. En France, c’est quand même la spécificité, c’est que la santé publique est nationalisée en quelque sorte et que les politiques, les médecins qui relèvent de l’État et les fonctionnaires aussi maintenant font attention je pense et réfléchissent à leur note je suppose...parce que, quand même, au cours de cette affaire, on a sorti des notes de conseillers des Ministres, on a sorti des documents, enfin voila. Donc...je pense que ça a des effets probablement sur le travail de ces gens là. Mais je ne l’ai pas mesuré, je ne sais pas. Je peux vous envoyer la thèse en PDF ci ça vous intéresse. Dans mon livre, c’est moins l’affaire du sang contaminé mais plutôt l’évolution du traitement de la médecine, c’est une partie de ma thèse sur comment s’est transformée la médiatisation de la médecine en France. Des années 1950 à aujourd’hui, alors je ne sais pas si ça peut, ça je peux vous envoyer la référence, malheureusement je n’ai pas d’exemplaire, je ne peux pas vous en donner un...il y a le documentaire de France 5 je pense, mais je pense que si vous connaissez l’affaire...

A – Parce que ça porte plus sur quoi le documentaire ?

B – C’est quand même beaucoup plus sur...c’est une espèce de....ce qui peut être intéressant pour vous, c’est que ça fait une espèce de synthèse de l’affaire. Pas beaucoup sur le droit, mais ça vous rappelle les grands....donc je pense que c’est bien pour vous car ça vous rappelle...ça vous donne une image générale de l’affaire. Mais ils interviewent surtout des scientifiques. Mais très peu de....ils n’interviewent pas de magistrats par exemple. Ce qui est dommage d’ailleurs, mais il y a un devoir de réserve aussi. Mais je pense que ça peut vous aider à avoir une synthèse, et puis il y avait....mais je ne sais pas si vous connaissez ce travail, il y avait un chercheur américain qui était venu me voir et qui s’appelait Douglas Starr.

A – Ah Douglas Starr ?

B – Donc voila, qui a aussi fait des comparaisons etc....Vous devez connaître par ce que c’est votre domaine et puis sur le droit, voila, il faudrait que je retrouve...

C – Marie-Angèle Hermite ?

B – Oui, voila, c’est un peu la référence sur le droit. Mais de mon point de vue, c’est très normatif. Je ne sais pas si je me fais comprendre. Elle est très normative.

A – C’est très juridique aussi.

B- Voila, c’est ça. C’est-à-dire que nous, en tant qu’approche sociologique même si on a été mal compris parfois, ce que l’on essayait c’était de comprendre comment un scandale émerge. Ce n’est pas de dire il y a scandale ou il n’y a pas de scandale. Mais de dire pourquoi il y a scandale et pourquoi à ce moment là. C’est un peu ça la question et comment les médias y ont contribué. Pour nous c’est une démarche qui n’est pas toujours comprise parce qu’on n’est pas dans le procès justement.

A – En fait le procès il représente le changement en France en général quoi, ça représente un changement quand on fait un procès.

B – Le procès au sens judiciaire ou le processus ?

A – Non, non. Le procès judiciaire.

C - Est-ce qu'il y a eu un changement au niveau des medias, des politiciens ?

B – C'est-à-dire là, c'est pratiquement la première fois que des grands médecins de la santé publique en France se retrouvent au tribunal. Avant c'était plutôt des faits divers, c'est très rare. C'était des faits divers, d'habitude c'est un médecin qui a fait une erreur d'anesthésie, qui a donné un mauvais médicament, voilà, ou qui a tué quelqu'un. Mais là, c'est la première fois que des scientifiques de l'État se retrouvent au tribunal et que des hommes politiques se retrouvent au tribunal sur...et ça c'est....quand même un gros changement et ça révèle quand même une transformation du rapport aux institutions, de la critique des institutions. Moi par exemple ce qu'on a essayé de montrer dans notre travail, c'est comment a émergé dans cette période le journalisme d'investigation et des journalistes qui étaient...et c'est moins le cas aujourd'hui, politisés....plutôt à gauche et ça a eu beaucoup d'effets aussi, derrière aussi, c'est le pouvoir socialiste qui était accusé. Ça c'est important. La dimension politique de cette affaire est très importante, elle rejoint...les deux choses, ce sont quand même des politiques et des scientifiques qui se sont retrouvés dans un tribunal. Et ça c'est très rare, c'est très rare, très, très rare. En France en tout cas.

A – Et depuis l'affaire du sang contaminé, c'est devenu un peu plus « normal » de...

B – On va voir, on va voir. Il y a eu depuis des politiques qui sont allés devant un tribunal mais la Cour de Justice pour l'instant c'est tout de même...c'est la seule affaire....maintenant....il va y avoir peut être d'autres affaires, je ne sais pas. Mais en tout cas, il y a une dimension très politique dans cette affaire, ce n'est pas un hasard...si ce sont des journalistes de gauche, si c'est le pouvoir socialiste qui est attaqué. Je pense qu'il y a une forte dimension politique. Et d'ailleurs, la plupart des conflits à l'intérieur du milieu scientifique, à l'intérieur du milieu judiciaire, à l'intérieur du milieu journalistique, c'est aussi des conflits politiques. C'est des visions du monde différentes qui s'opposent et qui contribuent à faire émerger le scandale. Parce que il ne fait pas oublier quand même que les gens qui ont donné des documents aux journalistes...les premiers en tout cas...ça c'est retourné contre eux. Par exemple le document qui est du CNTS, le document que Anne-Marie Casteret publie dans l'événement du jeudi, c'est quand même Jean-Pierre Allain qui lui a donné. C'est quand même très intéressant.

C – C'est vrai ?

B – Oui, il l'a confirmé. C'est intéressant, c'est tout de même très intéressant.

C – Où ?

B – Dans une interview, je ne me souviens plus, *Paris Match*. Et moi j'avais parlé avec lui aussi et il avait confirmé.

A – Et pourquoi ?



B – Je pense qu'il avait surement des comptes à régler avec Monsieur Garetta. Enfin, c'est tout ça un scandale, c'est un conflit de personnes, un conflit politique, un conflit de vision, des conflits d'argent, mais oui, oui, ça a quand même transformé la santé publique et puis les rapports entre la justice et la politique quand même. Ce n'est pas rien, et c'est pour ça que, par exemple, des nouveaux scandales comme le Médiateur, ça peut être très intéressant parce que là il y a des laboratoires privés. Donc on va voir car là, il y a l'État, il y a toujours l'État, il y a toujours les journalistes. Mais là il y a le laboratoire privé, ça va être intéressant de voir.

A – J'espère que j'ai répondu, je ne sais pas si c'est intéressant pour vous.

B – Oui, oui.

A – Et vous avez un article que l'on a écrit ensemble avec Patrick Champagne, « Acte de la Recherche en Sciences Sociales ». En 1994. Vous pouvez trouver ça.

## TRANSCRIPT OF INTERVIEW

A

DATE: 3 FEBRUARY 2011

**RESPONDENT:** I went to medical school in Paris and got my degree in sixty-seven and I went to do haematology and as part of haematology I was doing blood clotting which made me interested in coagulation factor, factor eight and nine then from there in haemophilia. When I was assistant professor of haematology in one of the university hospitals in Paris I was offered to become the director of a haemophilia centre in Paris and I took that job for seven years and I started home treatment and self treatment for haemophiliacs in France so I was the first one to work on that. And that has become for a long time the standard of care since then and then my family and myself thought that the emotional involvement with all these patients was too much I was too much involved I was neglecting my family and all of that, so I decided to stop and go to the National Blood Transfusion Centre in Paris where I continued to have an outpatient clinic every week for haemophiliacs but beside that I was doing research and ultimately research and development for, plus my derivatives, so I was preparing and developing new products out of donor plasma. And then the issue of HIV came up in '83, '84 and the director of the National Blood Centre in Paris who hired me and had for who I had the greatest respect for Professor Soulier, retired, and another person took over and over this issue of haemophilia treatment and concentrates and heat treatment and so on, we had very serious disagreement.

**INTERVIEWER:** Is this Michel Garetta?

**RESPONDENT:** Yes, to the point that he fired me that's why I went to the United States.

**INTERVIEWER:** So you left? When did you leave to go to the United States?

**RESPONDENT:** That's one of the irony of the thing that he, because I was pushing as much as possible to get heat treated products and was opposing his strategy...

**INTERVIEWER:** For self sufficiency in bringing in new...

**RESPONDENT:** He fired me! Despite that the media, the legal system and all that put both of us in the same bag, totally you know, dismissing this very important fact!

**INTERVIEWER:** And when did that happen? That you came to a parting of the ways?

**RESPONDENT:** It was in the beginning of eighty-five and I left in March eighty-six so we have been disagreeing and battling for over a year before he finally fired me. So that's why I went to the United States.

**INTERVIEWER:** It's just interesting to me in relation to the way you had a haemophilia treatment centre attached to the CNTS in Paris.

**RESPONDENT:** No it was attached to the French Red Cross.

**INTERVIEWER:** The French Red Cross? And that the blood donation centre was part of the whole...

**RESPONDENT:** No it was totally separate; it was a totally separate entity because in France the Red Cross is not involved at all in blood transfusion contrary to what's in Australia for example.

**INTERVIEWER:** So you were employed by, not the Red Cross, but by?

**RESPONDENT:** The National Blood Transfusion Centre.

**INTERVIEWER:** Okay but your treatment or the provision of treatment was separate?

**RESPONDENT:** It was within my outpatient clinic which was within the National Blood Transfusion Centre.

**INTERVIEWER:** Okay, your involvement with haemophilia treatment was a separate activity?

**RESPONDENT:** Yes.

**INTERVIEWER:** Okay I understand. **0:05:00**

**RESPONDENT:** So it was sort of a side activity.

**INTERVIEWER:** Just reading about the history it seems like the CNTS and haemophilia treatment was all joined together and that was just one of your many duties.

**RESPONDENT:** No, not at all.

**INTERVIEWER:** Not at all, that something you did?

**RESPONDENT:** However because I was a treater and I had a reputation and knowledge about haemophilia when I was at the Blood Transfusion Centre I was asked to be the interface between the Blood Centre and the clinicians of haemophiliacs and these clinicians had a group where things were discussed. So that's why I was on both sides.

**INTERVIEWER:** I don't know if it was like this in France I know it was in other Western countries but blood transfusion was sort of kept quite separate from a lot of the mainstream, I suppose clinical activities, it wasn't well integrated, maybe now but back then in the 70s and 80s.

**RESPONDENT:** It has never been, because actually it's, they are supplying a critical drug if you want, so I mean there has been some clinical activity within Blood Transfusion Centres particularly when the people in charge of a given blood centre came, like most of them, from haematology and wanted to continue having a clinical activity. For instance Professor Soulier who was the Director of the National Blood Transfusion Centre had a double appointment as Professor of Haematology in a major hospital.

**INTERVIEWER:** So it was more integrated in France?

**RESPONDENT:** Yes... well I wouldn't say integrated but there were a number of people in the blood transfusion services who had appointments in the University contrary to what happened in this country or none of them did actually I was the first appointed person in charge of a blood transfusion centre, appointed Professor of Transfusion Medicine in the UK; not in the UK because, there was one in Scotland, but in England.

**INTERVIEWER:** It seems also that the French Blood Transfusion Service is quite regionalised so what happens in Paris, you didn't have much or no control over what happened in the regions?

**RESPONDENT:** That's right, for instance there was quite a bit of competition between Paris and Lille.

**INTERVIEWER:** In terms of fractionation in particular?

**RESPONDENT:** That's right, well also in terms of haematology because the Director of the Lille Blood Centre also was a Professor of Haematology at the university so there were a few of those.

**INTERVIEWER:** From other reading we did too, we noticed the role of Soulier was very central to the development of blood transfusion in...

**RESPONDENT:** That was because he was a very remarkable person and he was very good scientifically, that's what attracted me to work with him but unfortunately he wasn't, like many scientists, good at administration.

**INTERVIEWER:** That's why they brought in a Garetta type to sort of take over?

**RESPONDENT:** That's right, which is going to the other extreme, somebody who was reasonably trained in administration but had absolutely no interest or credibility scientifically was a worse disaster than the other way around so that was a major issue actually.

**INTERVIEWER:** So even during the time working together there wasn't that much collaboration between you and Garretta, or you had to come together to deal with, say for example, the risk that began to emerge, of HIV or it wasn't like that?

**RESPONDENT:** Well, he wasn't really interested except he was interested in how that interacted with the Blood Transfusion Centre's business so that was his main

interest and obviously because the treatment of haemophilia was a substantial part of the organisation's activity he was very interested and that's why he set up a special relationship with the President of the Haemophilia Society and they had meetings regularly one on one and I have obviously no idea of what happened there but to a very large extent the decisions were taken together, in conjunction and it was quite interesting to see that during the legal process, the Haemophiliac Society and its representatives (interruption knock on door) absolutely denied such a thing when in fact all the decisions taken about the distribution of product, a kind of product, the collaboration for heat treatment etcetera, etcetera, was taken in perfect harmony with the Haemophilia Society. All of a sudden when they were asking for money, they'd become amnesic! **0:10:52**

**INTERVIEWER:** Certainly the way it's been presented it to us is that the Haemophiliac Society had no knowledge of any emerging risks.

**RESPONDENT:** That's absolutely ridiculous they knew perfectly from A to Z, but unfortunately the president of the Association at the time when the legal procedures came through, had already died of HIV infection so he wasn't there and it was the vice-president.

**INTERVIEWER:** Who didn't have that background?

**RESPONDENT:** Who was not haemophiliac but had two sons with haemophilia, lied, I mean although he was a very respected (inaudible, French) I don't know how you say, you know from the best tradition of French high level administrators and all that, he lied I mean like I don't know what and he denied any knowledge when he knew everything so there are in this business a certain number of people who committed perjury and he is certainly one of them, not the only one, but certainly one of them.

**INTERVIEWER:** To what extent was Garetta pursuing an agenda of his own or do you think that he had the support of the French administration or politicians to pursue self-sufficiency?

**RESPONDENT:** Of course, of course it was delegated to him to deal with it and he had, he established, he was an astute politician so he covered his back with the Ministry of Health just as well.

**INTERVIEWER:** So they were supporting him in his activities?

**RESPONDENT:** Absolutely.

**INTERVIEWER:** Insofar as France becoming a leading...

**RESPONDENT:** So his main opposition came from the treaters.

**INTERVIEWER:** From the treaters, yes? To what extent were the haemophilia doctors organised in their response to Garetta?

**RESPONDENT:** They were not organised unfortunately and actually it was each one for one's self except in this Ministry of Industry and Research grant where I put together a group, a research, scientific study group.

**INTERVIEWER:** So it was three groups?

**RESPONDENT:** Of this issue, called the MIR, Ministry of Industry and Research, actually who was started by a famous immunologist, (inaudible, French 0:13:28) anyway so we had a group of, including six haemophilia treaters from different haemophilia treatment centres and a separate immunologist, virologists and so on. So we did this study which provided most of the information we were trying together between '83 and '86.

**INTERVIEWER:** I gather that there were three different groups or something that were studying different aspects, is that right?

**RESPONDENT:** No it was one group and there was another group which was trying to do something which was (inaudible, French 0:14:08) with Doctor ??? and there was a third group in Lille, precisely. But none of them really came to anything much but the group I was coordinating did very good work.

**INTERVIEWER:** Is that the research published in journals like Blood, that sort of thing?

**RESPONDENT:** That's right.

**INTERVIEWER:** How did that study kick off? Was it you sort of saying we need to study the...

**RESPONDENT:** It kicked off in the following way, that you know we were hearing what was happening in the United States and this business of haemophiliacs with immunodeficiency with deficiency in their CD4 cells that had the same, and so I happened to know an immunologist in Paris and I asked his advice and he told me there is this laboratory in one of the hospitals who can do the count of CD4 cells so I sent him samples from some of my patients, outpatients to look at it and that's how it started. We found some with abnormalities and then a colleague of mine at CNTS was doing the same thing at the level of various blood transfusion centres instead of being directed towards haemophiliacs. **0:15:37**

**INTERVIEWER:** So people who were just donating blood?

**RESPONDENT:** That's right, and then he had some data and so somewhere at the end of '83, early '84, we decided to put together some coordinated study and Professor Soulier who knew everybody, he managed to connect us with this Ministry of Industry and Research to get funding. So we got, I don't know, 800,000FF, something like that, and so that's how we did the study.

**INTERVIEWER:** And the findings from the study were showing I gather by '84 that there was a certain, it looked like there were several haemophiliacs that had some degree of immune deficiency?

**RESPONDENT:** That's right, and then at that time at the Pasteur Institute, Françoise Barré who thank god, got the Nobel Prize out of it, a good friend of mine, was putting the HIV in culture and provided the reagents to do some testing for antibodies.

**INTERVIEWER:** So this was sort of experimental at this stage?

**RESPONDENT:** Yes and so during '84 there was some testing being done and we reviewed it in December '84 and concluded that there was a substantial number of haemophiliacs with abnormalities and that these abnormalities were less when patients were treated with cryoprecipitate which was not in pools, not in large pools.

**INTERVIEWER:** It was a single unit thing.

**RESPONDENT:** Like in the others so we started to have some idea of what was going on and then at this particular meeting interestingly, we discussed information of patients and the decision was taken upon the advice of the virologists, two of them also committed perjury during the trial by denying that they had advised against informing the patient, but anyway. Then they decided we didn't know enough about the significance of these antibodies and therefore we were not in a position to tell anything to the patients upon which one of my best friends with whom we had set up this group, resigned because it is agreed. I didn't resign although we discussed it at length because I was coordinating the study and I said, you know, if I resign the study is going to pot and we cannot afford it so I stayed, unfortunately I should have resigned, retrospectively, but anyway... so, and it's only, so that was in December and it was only in May when there was the annual meeting of the Haemophilia Society where there was a medical commission that reopened the discussion with my colleagues and they finally agreed that we should inform the patients so it was six, five months later.

**INTERVIEWER:** I suppose at that time you were still waiting for an official test to become available? There was that debate about Abbott?

**RESPONDENT:** Yes, at the beginning of eighty-five in March to be exact, there was the first assay, the first commercial assay that was available, its performance was not very good but at least it was something and so it's only in July that screening started, in '85.

**INTERVIEWER:** Is that when French haemophiliacs were formally tested for the first time and informed, from that point on?

**RESPONDENT:** Yes, so as soon as this decision was made, personally I called upon every patient I had in my outpatient clinic and had a one on one session of information, so yeah that's how it was. **0:20:06**

**INTERVIEWER:** The other thing that's interesting in our research too is to note that although there was this commitment to self-sufficiency and supposedly it had been achieved by 1984, there was still a fair amount of importation going on?

**RESPONDENT:** Yes, about thirty per cent.

**INTERVIEWER:** Is that just because they couldn't get access to enough product or because people prefer different products by different manufacturers or...?

**RESPONDENT:** No, that's another interesting twist in the story, is that in eighty-three there was this national meeting of the Haemophilia Society where there was a debate about prophylaxis for haemophiliacs and in this debate Professor Soulier and myself argued that it would be prudent considering what we heard here and there to consider coming, going back to cryoprecipitate treatment and we were outvoted by the haemophiliacs themselves and supported by a couple of their treaters, saying that concentrate was so much easier and they wanted to lead a normal life etcetera, etcetera. So they asked for more importation of concentrates and so on, so that was...

**INTERVIEWER:** Even though I suppose Paris had a strangle hold or monopoly on importation, clearly there were other avenues of importation?

**RESPONDENT:** Well because obviously there were political issues and the political issue was self-sufficiency and that's why the Ministry of Health asked CNTS to be the only port of entry of these imported products to try to limit it to the minimum so it was the very clear directives of the Ministry of Health and that's why the CNTS was appointed to do that and because I was the haemophilia specialist Soulier asked me to be in charge of doing the evaluation of these products in patients to make sure that they were...

**INTERVIEWER:** Both French and foreign so to speak?

**RESPONDENT:** Yes they were meeting on such a number of criterias that had been defined previously so that's how I was again at the interface between users and providers.

**INTERVIEWER:** Also from what we've read as well where there were first reports coming in that people with haemophilia were, had signs of HIV or AIDS, that those blood banks for want of a better word sort of, they knew that there was probably a mixture of French and American concentrates involved but the emphasis was perhaps placed more on it being an American problem?

**RESPONDENT:** Yes.

**INTERVIEWER:** How, to what extent was that emphasised?

**RESPONDENT:** It was ... it was certainly in people's minds at the time saying all of this is because of the imported products it comes from America and the French products are much better, which turned out not to be true. Although it was, it took a longer time to become infectious for the French because the epidemics of HIV had some kind of delay in time compared to the United States and, but as soon as the products were made in large pools which was between one and five thousand or even ten thousand donations, then the contamination was similar.

**INTERVIEWER:** Is that the sense that France would escape the scourge of HIV because of its, the commitment to gift relationship to the unpaid donor, that would seem to be very strong?



**RESPONDENT:** No, no, no there was no paid donor involved.

**INTERVIEWER:** Unpaid sorry.

**RESPONDENT:** Because even in the United States there was no paid donors since 1976.

**INTERVIEWER:** Involved in plasma?

**RESPONDENT:** That's right so it was plasma, plasmapheresis donors. But if you take the example of the Belgian situation where the clinicians convinced the patients that it would be prudent to use cryoprecipitate, then their rate of infection was a fifth of what it was in France. **0:25:09**

**INTERVIEWER:** I think you did some comparative work on that didn't you?

**RESPONDENT:** Yes it was ten per cent and in France it was forty-five close to fifty per cent so retrospectively it justified what Professor Soulier and I proposed in eighty-three and was totally dismissed by the haemophiliacs for other considerations.

**INTERVIEWER:** In terms of, would you have been able to switch to wholesale use of cryoprecipitate? I know in England it was a big issue.

**RESPONDENT:** It was doable.

**INTERVIEWER:** I think in England now there are concerns that there would be another...

**RESPONDENT:** Yes because before the concentrates were available and that's what they were treated with. I mean obviously there was an issue that because of the change in the treatment regimens, the demand increased but it could have been done.

**INTERVIEWER:** Were CNTS involved in collecting blood from prisoners or was that more of a regional thing that was going on at the time?

**RESPONDENT:** About what?

**INTERVIEWER:** Collecting prison blood donations.

**RESPONDENT:** Yes, again it was the discretion of every director of blood centres at the time there was one per department so it was over a hundred centres.

**INTERVIEWER:** Yes, is that something they did in Paris or not?

**RESPONDENT:** No I mean it was actually recommended by the Ministry of Justice.

**INTERVIEWER:** Was it, right. Sort of an act of social solidarity?

**RESPONDENT:** That's right because they thought it was sort of a way of rehabilitating inmates, that kind of thing. But since, I don't know, maybe fifty percent of the incarcerated population was IV drug abusers...

**INTERVIEWER:** It was a risk group, definitely was. I get the sense from the reading we did that in those earlier years before the mid-80s too, that although there were people doing research such as yourself, Luc Montagnier or whatever, that it wasn't all joined up very well, was it through informal contacts that you would find out about research that was being done in the HIV/AIDS area.

**RESPONDENT:** Well Montagnier had established his own group and they were meeting once a week but that marginally involved one person from the blood centre which was Doctor Habibi who was part of that group, but it didn't really transpire on the other side, on the transfusion side. And on the transfusion side there was this study group I mentioned which included some people, two virologists who were closely connected with the Pasteur Institute and at least in theory Montagnier was also a part of it because he was a co-author on the papers and all of that which he denied in front of the court I mean it was, that's another perjury one, anyway... so you know a number of people who had a very active part into that when they came in front of the court they forgot what they had done and where they were and what their responsibilities were.

**INTERVIEWER:** Right, but your recollection is that there was information flowing between the different groups or at least there was representation?

**RESPONDENT:** Not much.

**INTERVIEWER:** There was not much at all, okay.

**RESPONDENT:** No it was quite, quite segmented.

**INTERVIEWER:** Segmented, okay and when it came to eighty-five and HIV testing is it your memory of the time that there seemed to be a lot of bureaucracy or delays, it was mainly financial because that's certainly how, the slant that's been put...

**RESPONDENT:** Well to tell you the truth I was only marginally involved particularly because I was battling with Garetta all the time so he excluded me from a lot of the meetings and decisions.

**INTERVIEWER:** He would be the main person?

**RESPONDENT:** Yes.

**INTERVIEWER:** So you left formally and finally in March '86?

**RESPONDENT:** Yes.

**INTERVIEWER:** And you went to the States, to Chicago and you were working over there and you returned to France? When?

**RESPONDENT:** Never, I mean except when I had to for the trial.

**INTERVIEWER:** Sorry I thought you had...

**RESPONDENT:** No, I came directly from Chicago to here. So I was in Chicago in eighty-six and I came here in '91 after five years in Chicago.

**INTERVIEWER:** OK, I suppose just to get a sense of how did Anne-Marie Casteret make contact with you, how did it all sort of kick off in a sense?

**RESPONDENT:** Well, I was in my office in Chicago and I got a phone call from one of the haemophiliacs I was treating and he told me that he was desperate because he had tried to get compensation from the government and it was going nowhere and he really asked me with a crying voice to help him. So I said well what can I do? Well there is this journalist who is working on it and trying to help us, could you see her? So I said well why not? So after that she contacted me directly and we set up a meeting so she came to Chicago to discuss and then she said do you have any documents? So I consulted with my wife and we discussed all night to decide what to do because I had a few documents and ultimately we decided that I had to do what I could to help my patients. So I just photocopied in the middle of the night the few documents I had and gave it to her so that's how it started. **0:31:36**

**INTERVIEWER:** And at the time was it just done on the condition of anonymity or you just said do what you want with it?

**RESPONDENT:** It didn't cross my mind that it would come to anything I just wanted to help a patient that was it.

**INTERVIEWER:** What happened after the event?

**RESPONDENT:** Well the next event was that I was contacted by the FBI.

**INTERVIEWER:** The FBI?

**RESPONDENT:** Yes and the FBI told me we have received a request from the French legal system to interview you so one of these investigating judges came to Chicago to interview me.

**INTERVIEWER:** And that was?

**RESPONDENT:** That was '90, end of '90 it was in the winter I remember so that's how the legal thing started.

**INTERVIEWER:** You mentioned earlier that you had a sense when, I don't know if this is the judge that you were talking about that you had a feeling there was a clear agenda of what they wanted, was that apparent from that interview as well or was it more of a sort of open-ended...

**RESPONDENT:** Well I think at the beginning at least apparently this particular judge seemed to be in reasonably even spirit but then progressively I saw it change for whatever reason I mean there must have been some external pressure but it

became more and more obvious that whatever could be said it didn't really matter so they can pick and choose what they wanted for a pre, pre, predetermined objective.

**INTERVIEWER:** When you said it progressively began to change you identified that as perhaps being political pressure?

**RESPONDENT:** That's how I interpreted it.

**INTERVIEWER:** And perhaps the media spotlight because obviously Casteret had published her work by this time.

**RESPONDENT:** That's right.

**INTERVIEWER:** But of course you were not there you were in the States. Would it be correct to say that you didn't have a sense of the raging storm?

**RESPONDENT:** I had no idea, I had no idea. And actually it's then when I was appointed here so I came in April '91 and then after a year, at the end of '92 then and there was a change in the process but initially I was called by the legal system for the information and there was no indication that I could be indicted or anything but then when I came here at the end of ninety-two then it was for indictment and all of that and I had to go to Paris and have several interviews with the judges and so on and so on, and so the whole machine started kicking off.

**INTERVIEWER:** Did you get legal representation right from the start off when you were being investigated or when the judges came to see you or were just on your own?

**RESPONDENT:** No that's not quite true because at the first interview back in Chicago, the company I was working with were very nervous and so one of the company legal advisors came to the interview and then she quickly realised that it had nothing to do with the company and then disappeared!

**INTERVIEWER:** But by the time you were going to Paris, once you'd been...

**RESPONDENT:** Yes the first two or three interviews which was what they called just you know, *témoign assisté*.

**INTERVIEWER:** Witness assisting.

**RESPONDENT:** I said assisted by whom? Then they said you can have a lawyer, you are not indicted but it might be a good idea to have lawyer. **0:35:48**

**INTERVIEWER:** So there was no official warning given?

**RESPONDENT:** No, so you know I had used a lawyer for my divorce so I just called him up he was just an ordinary person so he came with me once then I realised he was definitely out of his league so I hired another later.

**INTERVIEWER:** Did you have different legal representatives through the whole saga or was there just one that you stayed with?

**RESPONDENT:** Okay so after I changed I stayed with the same for three years.

**INTERVIEWER:** OK, I'm interested to know did the advocate or the legal representative sort of see where it might have been going or even they were taken by surprise at the turn of events?

**RESPONDENT:** Absolutely they didn't have any idea of what was going on. Which is to me an additional indication that it wasn't a legal issue, but it was a political issue that's why they didn't know any better than I did.

**INTERVIEWER:** So, you are interviewed by the investigating judge and then are you given a chronology or what you knew was going on at the time?

**RESPONDENT:** I was in the position (laugh) that the judge initially was very nice etcetera and she wanted to learn so she took me as, as a teacher.

**INTERVIEWER:** So, so you were like an expert assistant?

**RESPONDENT:** That's right, that's right so I was a cheap one!

**INTERVIEWER:** Hopefully they paid your expenses to get to Paris!

**RESPONDENT:** And then, and then she turned around completely and actually indicted me! So it was a cheat in many ways I should have not tell her anything but I tried to make her understand what the situation was and so on.

**INTERVIEWER:** So, how were you informed that you were going to be indicted? How did that process take place?

**RESPONDENT:** I forgot.

**INTERVIEWER:** You sort of, because you would have been in England surely?

**RESPONDENT:** Yes so I was going back and forth.

**INTERVIEWER:** You were going back and forth all the time so you realised obviously and you're told obviously you were going to be charged with a criminal offence?

**RESPONDENT:** No actually it wasn't because the legal frame they chose which was very astute, was a frame that did not require experts.

**INTERVIEWER:** You mean the fraud, or the deception?

**RESPONDENT:** Right.

**INTERVIEWER:** What do you mean they did not require experts?

**RESPONDENT:** That's the legal system in France that if you call for claiming fraud and the quality of a product that you can have in the supermarket or anywhere you don't need an expert.

**INTERVIEWER:** To advise the court you mean?

**RESPONDENT:** Yes, yes but if you were in a criminal situation then you can have experts and they knew from the beginning that if there were experts then there was no case because it was so obvious so that's why they stayed on this product fraud so that they didn't need experts, they could bypass them completely and decide what they wanted so it was open territory. So you know they could decide on whatever they wanted because they couldn't be contradicted by experts and that why precisely they chose this particular legal frame to avoid the experts.

**INTERVIEWER:** And your legal representative and yourself realised this fairly early on or when it became apparent as to why they made this choice later?

**RESPONDENT:** To me it became apparent during the trial.

**INTERVIEWER:** Okay, because of the way...?

**RESPONDENT:** Because I saw two or three of the lawyers on the haemophiliacs' side who, you know, clarified it and said, oh you know, when my lawyer or maybe another one said okay but why don't we have experts? They said we don't need experts it's not in the law in this kind of situation we don't need them and it was this dismissal.

**INTERVIEWER:** They literally called what no experts to assist the judge, the trial?

**RESPONDENT:** Absolutely they said we don't need it, that they are not required, forget it. So that's how people were convicted because they chose a legal frame that didn't require experts, very clever. **0:40:35**

**INTERVIEWER:** Because it seemed to, certainly some of the stuff that I've read too that there would be a number of accused that they had to identify and you were one but they could have chosen a range.

**RESPONDENT:** I told you why I was one of them, because I was expendable.

**INTERVIEWER:** Perhaps you could explain why you thought you were expendable.

**RESPONDENT:** Well I was expendable because I was on my own, you know, I came from America I had left France for seven years and I was in the British context and the British context had nothing to do with what happened in France, twenty years, fifteen years earlier and so I was not supported by, I don't know, the equivalent of the GMC and other doctors' organisations in France or *L'Ordre des Médecins* I wasn't part of the how do you call it, the *assistance publique* or I wasn't

part of a blood centre, I wasn't part of, so I had no attachment to France so I couldn't be defended by the system, I was on my own, so I was an obvious target.

**INTERVIEWER:** Did you ever think I'm just not going to go back to appear?

**RESPONDENT:** I did appear.

**INTERVIEWER:** I know but did you ever think I just won't enter France?

**RESPONDENT:** No it didn't because my life was in Cambridge and I was doing... I still do, so I like that and I was so disgusted with the system in France and how things were going but I certainly didn't want to back to France.

**INTERVIEWER:** So when you were notified obviously that the trial was going to take place, you had legal representation, what are your memories or experience of that trial? Of the parties, did you present a case, did you bring any experts or...?

**RESPONDENT:** Yes I did actually and I remember two of them, one immunologist and one haemophilia treater from Italy came and discussed and they were turned into ridicule. Like for instance, the immunologist...

**INTERVIEWER:** By whom?

**RESPONDENT:** By the legal people, the president of the tribunal, the prosecutor and everybody made fun of them because I remember the immunologist mentioned that there was some experiments about the infection with HIV in chimpanzees and it was oh doctor chimpanzees well blah, blah, blah and they turned them into ridicule, they didn't even listen to what they had to say so that's how they treated experts!

**INTERVIEWER:** Obviously I gather the Haemophilia Society would have had separate representation? And put forward arguments, so did you go into the witness box yourself, were you cross examined?

**RESPONDENT:** Actually at the initial trial no, actually in the appeal trial it was much more liberal because the president of the tribunal accepted that the indicted people could ask questions, but not in the first trial.

**INTERVIEWER:** You mean yourself or your legal representative?

**RESPONDENT:** I was only entitled to answer questions.

**INTERVIEWER:** To answer questions?

**RESPONDENT:** Yes.

**INTERVIEWER:** Not to ask them?

**RESPONDENT:** Not to ask anything.

**INTERVIEWER:** That's standard procedure? Because it would be very strange in an English court that you wouldn't be actually able to ask questions or cross examine or anything, so you were just permitted to answer questions that are put to you by?

**RESPONDENT:** By the judge, mostly by the prosecutor.

**INTERVIEWER:** Directly to you, not even through your legal counsel?

**RESPONDENT:** Yes.

**INTERVIEWER:** I gather that there was a fair amount of media coverage of this trial at the time, again were you aware of the level of media interest in what was going on?

**RESPONDENT:** I had certainly no idea of, it is how much power they had and how they were manipulated by the legal system but mostly by the haemophiliacs themselves and the way things were arranged was very clever, that you know, there was the public so there was the judge and the president and his assistants and then there were the lawyers and then the next row there were haemophiliacs and particularly the small ones that were the next rows and then the general public was totally at the back. So just in front of the judges you had this kind of wall of pain if you want that was a constant pressure for them so it was psychologically very powerful and they utilised that to the extreme. **0:45:47**

**INTERVIEWER:** I know that there has been, the legal tradition shall we say in France, for certain show trials like Vichy and Dreyfus and so on, did you get a sense that you were participating in one of those show trials?

**RESPONDENT:** Yes and then admittedly it was in July so it was fairly hot but they opened the doors and there were some people screaming outside slogans and all kinds, there was all these pressures.

**INTERVIEWER:** Obviously, the media were reporting on all that, and obviously being fairly close to some of the people in the Haemophilia Society?

**RESPONDENT:** Of course. I mean I tell you because when I was in this blood centre and teaching young kids how to treat themselves and all of that you know I was like a father for them, I helped them and I made them go to school etcetera and I kept, to this very day I'm still in very close contact with two of them.

**INTERVIEWER:** What happened during the course of the trial, those relationships were maintained or there was a sort of adversarial situation during this period?

**RESPONDENT:** Well ... unsurprisingly they went where their interests were, particularly their financial interest so even if I had been very close to a lot of them, actually one of them had been separated from his family because he was beaten up by his father etcetera and he was living in my home!

**INTERVIEWER:** At the time?



**RESPONDENT:** Just, yes at the time, in '85, he lived in my home for a year! And he was one of the main proponents of ... and his lawyer was one of the most aggressive against me I couldn't believe that! I really took care of him for a year like my own children and... and a number of others that I taught how to treat themselves and all that and had with me for years when they were between eight and fifteen, were at the trial and ... they pretended there was no connection, that they forgot how close we were, because of where their, their monetary advantage was.

**INTERVIEWER:** It also seems that the haemophilia sort of, haemophilia-doctor relationship, was quite different because of that long relationship?

**RESPONDENT:** Of course.

**INTERVIEWER:** Yes, so in terms of disclosing risk, well it was said that it was a different sort of relationship to perhaps you find in the average doctor patient relationship.

**RESPONDENT:** Completely, completely because that's the thing with chronic diseases, that you see the same doctor over and over regularly, the same for diabetics, so you know? So you established a very different relationship to when you are sick you get a consult, you get your antibiotics, you go away, so it's very different.

**INTERVIEWER:** Yes, there was also a tradition I believe at the time of regularly taking blood samples and tests from haemophilia patients, doctors around the world because they are forever restoring blood and doing all sorts of tests, would that have been the case with yourself and other doctors in France as well ?

**RESPONDENT:** Yes, I mean depending on whether or not the physicians were more interested in doing some investigation and research and so on so it varied from one to the other. But certainly yes they have to be followed, and they have to have different tests for liver disease, for infection, for this and that.

**INTERVIEWER:** There's sort of a group of haemophiliacs, constantly the blood tests are being taken, they'd be looking at hepatitis and HIV, was it actually a different culture at the time, perhaps there wasn't the urge to disclose, this is specific for a HIV study or whatever, because there was that tradition of constantly taking blood. **0:50:09**

**RESPONDENT:** Yes but actually for those who were involved in this collaborative study, they were informed of the study and what they were doing and it was done appropriately but interestingly it was only in eighty-four that the very first ethics committee in France was set up.

**INTERVIEWER:** Because you would have done your study not with formal research ethics approval?

**RESPONDENT:** Because it didn't exist! Actually that was one of the issues that we discussed in our regular meetings, where is the committee we can approach to have some guidance on what to do? And there wasn't any.

**INTERVIEWER:** You look twenty years on and you can't move without them!

**RESPONDENT:** Yes, there was nothing!

**INTERVIEWER:** You were essentially self-directed in terms of your research?

**RESPONDENT:** Exactly so it was within the group, yes.

**INTERVIEWER:** Just going back to the trial then in terms of, obviously I'm assuming that relationships weren't great with Garetta? But obviously Roux was there and Netter, the other accused, was there much interaction between those involved?

**RESPONDENT:** Actually I had interaction only between Professor Roux who was the head of the Ministry of Health because I liked him, he was a really nice man, the other two I didn't care much for so I didn't have interaction with them and also he had a very interesting lawyer, an old lady who was really good ... I really liked her I think she was the best of the lot.

**INTERVIEWER:** Did you all have a similar strategy going in or was it more sort of surprise, why are we here? Or...

**RESPONDENT:** It was *chacun pour soi*.

**INTERVIEWER:** Sorry?

**RESPONDENT:** *Chacun pour soi* means each one on their own, there was no communication between.

**INTERVIEWER:** Did you get a sense as the trial was progressing that it was, shall we say you knew what was going to happen at the end? You were saying it was highly politicised?

**RESPONDENT:** I was so naïve that you know, I thought that it was obvious that there was no fault and that justice should prevail and it was a total surprise when it turned out not to be.

**INTERVIEWER:** So of course the verdict comes down?

**RESPONDENT:** Yes.

**INTERVIEWER:** You were surprised?

**RESPONDENT:** And then I appealed immediately because I was so outraged.

**INTERVIEWER:** So the appeal process, it goes to the... it's a fresh hearing isn't it?

**RESPONDENT:** Yes and what was interesting is that in the, I don't know how you call it, the reasons supporting the verdict of the first trial, there were as far as I was

concerned, four issues, one, two, three, four and then in the appeal trial three of these four dropped because it was proven wrong. But they found three more to replace and came out with the same verdict, I mean you know, totally fabricated.

**INTERVIEWER:** In terms of the prosecution was putting forward these three new events or three new... or the judges?

**RESPONDENT:** They just manufactured it because they had to find something to justify so, you know, it had nothing to do with the reality of what was discussed or the arguments that were made. I mean ...

**INTERVIEWER:** You said there were more options for you; it was more liberal, for you to call expert evidence?

**RESPONDENT:** No just to ask questions so the appeal judge was more liberal and you know, when Montagnier came and some others, lying you know? So I said why did you say that? Why did you say that the study we did was unethical when there was no ethical committee? Why do you say it was unethical when you were one of the authors of the paper? You know that kind of stuff.

**INTERVIEWER:** And his response was? That's not correct, no?

**RESPONDENT:** Yes, so you know, so at least this could be done but obviously the judges didn't listen to any of it but...

**INTERVIEWER:** So the finding was that your, I suppose the sentence or something was upheld or it was slightly changed, am I right? You said that you did end up having to go to jail, was that after this appeal process? **0:55:04**

**RESPONDENT:** Yes it was at the end of the appeal trial.

**INTERVIEWER:** Interestingly from our research we were struggling to find if doctors were convicted of any sort of offence or going to jail, it seems to be a very rare occurrence in France. We could not find any examples of it.

**RESPONDENT:** I have no idea, you should know! I think it's unusual for fraud on the quality of a food product that you go to jail where usually it's fines.

**INTERVIEWER:** Did Garetta as well? I know he was?

**RESPONDENT:** Yes he was incarcerated, his sentence was four years and two suspended and actually he went for more than twenty-four months because in the meantime there was this new thing about the poisoning.

**INTERVIEWER:** So that came directly after because that was raised on appeal wasn't it that there might have been an issue of poisoning so that kicked off the next set of investigations. So meanwhile you went to jail for thirteen months, is that correct? Is there a special, I don't know about the French prison system, where did they take you or what's involved in it?

**RESPONDENT:** I was what do they call it ... I forgot now, so I was separated from the general population in the prison and I was with people who were quote, unquote, at risk within the prison from other inmates so there were policemen, people in the legal profession and like that, so we were isolated.

**INTERVIEWER:** Was that more open in security?

**RESPONDENT:** So basically we had our cells, we had one classroom, that's how I got my Master's degree in psychology! (laughter)

**INTERVIEWER:** In thirteen months?

**RESPONDENT:** Yes because I had some background with my...

**INTERVIEWER:** I'm surprised you didn't study law so you could do a fight back!

**RESPONDENT:** (laughs) And we had a courtyard which was covered by an iron grid against a helicopter escape, I mean anyway, so we were something like twenty people and it was something like ten by eight metres, that's all we had and we had one ping pong table.

**INTERVIEWER:** And obviously facilities to study something?

**RESPONDENT:** Yes, so we had this programme with three teachers, we studied clinical psychology, philosophy and we had ... a yoga teacher.

**INTERVIEWER:** A yoga teacher?

**RESPONDENT:** Yes, that was interesting and I taught English and I did some painting, lots of writing and my children said that I gained a lot by being in prison! (laughter).

**INTERVIEWER:** I don't know what the situation is; I'm more aware obviously of what happens in England, where if you have served a jail sentence, what are the implications for you as a health care professional?

**RESPONDENT:** In this country, none, except for the blood service which was within the NHS so actually I was banned from being in this building so I had to be in the University facilities.

**INTERVIEWER:** Banned from this building? Because it was involved...?

**RESPONDENT:** Because this building belongs to the NHS.

**INTERVIEWER:** Oh so the NHS wouldn't accept somebody who had a ...

**RESPONDENT:** Yes.

**INTERVIEWER:** Okay, but you're obviously back here?

**RESPONDENT:** Despite the fact that two different commissions in this country vindicated me completely.

**INTERVIEWER:** So there were independent, because I was wondering what happened...?

**RESPONDENT:** So I had to go to another building across the street and I had meetings with my collaborators who were still here and they came to see me and we had lab meetings and so on and then after may be four years, I was permitted to enter the building.

**INTERVIEWER:** So they conducted internal enquiries?

**RESPONDENT:** Yes, this vindicated me completely. So despite that I was banned from the building.

**INTERVIEWER:** For four years essentially, but you could go to University buildings?

**RESPONDENT:** Yes because the University has been fantastically supportive.

**INTERVIEWER:** It seems like there was a great deal of support for what happened to you?

**RESPONDENT:** That's right, within the University, but not the NHS.

**INTERVIEWER:** Not the NHS? But also generally, amongst those within the UK generally?

**RESPONDENT:** Yes including the article in *The Lancet*.

**INTERVIEWER:** Yes I read that, but you just said it was variable in France?  
**1:00:01**

**RESPONDENT:** Oh, very variable.

**INTERVIEWER:** Or it wasn't there?

**RESPONDENT:** Because you know, I don't know, you know, people look after their interests, very few people care about justice or what's right they are watching for their own back and the rest of it they don't really care so .... but there were several very good surprises. People really stood up which I had, I had one I remember one paediatrician with whom I was a resident for a year and I had a reasonably good relationship with him but nothing special but he stood out in front of the press and said that I was a good guy etcetera so it was very nice.

**INTERVIEWER:** How do you think the media depicted you in France?

**RESPONDENT:** Doctor Jekyll and Mister Hyde.

**INTERVIEWER2:** I read that! Is that your sort of description?

**RESPONDENT:** They knew what I had done for the patients so they had to find something bad so they did, that I was jealous, you know?

**INTERVIEWER:** When did you realise that there was going to be a second investigation?

**RESPONDENT:** Which one?

**INTERVIEWER:** The poisoning one, you must have thought this is it, surely I'm free now? Or were you just sort of saying well, okay?

**RESPONDENT:** Well actually you know I was still in jail when I was first taken to this new investigation and she did exactly the same, even worse, than the previous one, to take me as an expert and I teach her, so she did exactly the same thing except that contrary to the other one she had an agenda from the beginning.

**INTERVIEWER:** That was clear was it?

**RESPONDENT:** Oh yes very clear that she was on the side of the haemophiliacs and she didn't want to know anything else so she was biased from the start. She was actually much more dangerous than the other one.

**INTERVIEWER:** Did you go through a series of interviews with her?

**RESPONDENT:** Many, I don't know maybe twenty.

**INTERVIEWER:** Twenty interviews?

**RESPONDENT:** Mm hm.

**INTERVIEWER:** Was it going over similar territory as before?

**RESPONDENT:** Yes, it was on a different note because it was nicer in a way, it was more humanised but it was much more vicious.

**INTERVIEWER:** What do you mean by vicious?

**RESPONDENT:** That she was setting traps and stuff like that and on the one hand saying you know, you are very nice tell me what happened and I need your expertise and blah, blah, blah and in fact doing things totally different in the back so she was not a good person at all.

**INTERVIEWER:** Were you aware that she was investigating poisoning issues or did that sort of emerge from...?

**RESPONDENT:** No it was clear from the beginning.

**INTERVIEWER:** It was clear from the beginning? So you were on notice that you could be drawn into this thing?

**RESPONDENT:** Yes but I mean the case was so, so weak that it came out to nothing and the Supreme Court decided that it wasn't an option and it was dropped.

**INTERVIEWER:** Did you still have the same legal representatives throughout?

**RESPONDENT:** Yes.

**INTERVIEWER:** And that was their view too, that it was not a strong case?

**RESPONDENT:** Yes except for in the French system if you go to the Supreme Court the *Cour de Cassation* you have to have a specific type of lawyer who are particularly registered for this particular court so I also had to have another lawyer specifically for the Supreme Court.

**INTERVIEWER:** Which wouldn't have come cheap I would have thought because they would have to be specialists?

**RESPONDENT:** Fortunately a friend of mine was one of them so that helped (laughs) a friend from childhood so that's the real ones.

**INTERVIEWER:** So obviously around this time the investigation was going on for poisoning but obviously then the politicians went on trial in 1999 and obviously the range of people being brought into the investigation was getting larger and larger as well wasn't it? Would that chime with your views that everybody might have been indicted or none at all if you know what I mean? Because the net was getting wider and wider it wasn't just the four of you, it was thirty plus people. **1:05:14**

**RESPONDENT:** Yes but I mean, you know, it was a chain, so obviously the doctors that were right there trying to understand what was going on didn't know what was happening, how could the politicians know what's happening? So you know because some of the scientists were advising the politicians, like the director of the Pasteur Institute and a number of other people so they didn't know any better obviously, they knew even less but they were dependent on what was happening on the ground which I was part of.

**INTERVIEWER:** Did you get a sense after a while that this whole thing had taken on a life of its own? Was completely separate?

**RESPONDENT:** Absolutely it didn't mean anything, it was totally, sort of (inaudible 1:06) of itself that was totally disconnected with any reality at all it was a political media business and that's it, with no ... connection with reality.

**INTERVIEWER:** Did you get a sense to that as a result of all these legal proceedings that there were significant changes brought about to the way they did blood in France in terms of blood safety or was it...?

**RESPONDENT:** Well, the consequences of it have been enormous, everywhere in the world and actually I'm working now on another subject and I've written a chapter in a book about transfusion in Africa. One of the things I noted is that the space taken by HIV to a large extent because of that, like in France in Canada and so on, has totally occulted much more important problems so it's all for HIV, a lot of

things have only been done for HIV and a lot of other things, more important from the true perspective of blood safety, has been totally occulted, ignored because the whole, the whole attention then money was directed to HIV. So actually it has done some good things because it drew attention to a number of things regarding safety but on the other hand it had the side effect which was to ignore a lot of other things that should have been at the forefront.

**INTERVIEWER:** Would you identify those as, say for example non-infectious risks?

**RESPONDENT:** That's what I'm working on at the moment, for instance malaria and malaria in developing countries, in sub-Saharan Africa is a much more important issue than HIV, HIV has been controlled pretty well for quite some time and also Hepatitis B, to have people really interested and looking into the problems for malaria, Hepatitis B in transfusion in sub-Saharan Africa, if you look actually a friend of mine did a survey and published a paper recently about transfusion and malaria and in the last twenty years he found eighteen papers.

**INTERVIEWER:** That's all?

**RESPONDENT:** That's all, for the whole world, can you imagine? Two papers a year.

**INTERVIEWER:** On Hepatitis?

**RESPONDENT:** No on malaria and transfusion.

**INTERVIEWER:** I know Bill Gates is interested in malaria.

**RESPONDENT:** Supposedly actually I contacted them I didn't have any answer.

**INTERVIEWER:** So, there are a lot of other things that really are obscured because of HIV.

**RESPONDENT:** Exactly it was at the forefront of everybody and it obscured any thing else and I think that's a very damaging consequence. Although as I said from another perspective it did unearth things because the procedure we have now and people pay more attention in the way things are done and how to control things and haemovigilance and blah, blah, blah. So there were a lot of good things coming out but also bad ones.

**INTERVIEWER:** Is it more precautionary now, that's the sort of buzz word that's being used. **1:10:02**

**RESPONDENT:** But I mean now we are at the other extreme which is the precautionary principle which is madness!

**INTERVIEWER:** How it is interpreted is quite different depending on who you are.

**RESPONDENT:** That's right.



**INTERVIEWER:** Just as, we're all interested in the experience of doctors and health care professionals who have found themselves in, before the courts and things like that, what would you take away from what happened to you? Is it just something you got caught up in?

**RESPONDENT:** A very pessimistic view of human nature, very pessimistic that whatever you do for people they forget as soon as their interest is involved and you can never trust people, you never know how they are really going to ... to ... react and you can be totally wrong about your assessment of anybody. I became totally cynical about human nature so I don't expect anything, if something's good, fine, but I don't expect anything.

**INTERVIEWER:** There might have been quite a few doctors who perhaps wouldn't have gone on with practice or wouldn't have stayed.

**RESPONDENT:** Yes some of them went away.

**INTERVIEWER:** But you obviously are still very involved and interested?

**RESPONDENT:** Absolutely because I feel totally free from that, it's I don't know, its like having a disease, an infection and then once, okay so you are cured from the infection it doesn't change you, it didn't change me.

**INTERVIEWER:** We're obviously also interested in the use of criminal law, even before the fraud charge there was a possibility that you could have been convicted and gone to jail over it which is what happened, do you think that there is a different way that you deal with medical issues where there is conflict or if there is an issue over whether the right thing was done or not, rather than resorting to the criminal law, what would you see as a doctor as a way of perhaps dealing with these sorts of issues?

**RESPONDENT:** I don't know! (laugh) I don't know, what I think would be desirable is to have an interim system so that you have a general fund of compensation and that if anything happened to anybody you go to this fund you get your money and that's it because all these legal procedures and all that cost so much money, so much aggravation to everybody that its really a waste of time and money. It would be much easier since, ultimately it is only a question of money.

**INTERVIEWER:** You don't think that the haemophilia groups, for example, were interested in finding out what happened or accountability issues?

**RESPONDENT:** Not at all! They were interested in getting money of course! Because these issues are very rare, right? They are exceptional so but if there was a genuine fault so there is an expected outcome of medical practice and if you get something and it's considered that there is the responsibility of the health care system, you get your money and there is a scale and for this you get so much and get on with it, that would be so much simpler, so much cheaper.

**INTERVIEWER:** Say for example a lot of government sponsored inquiries; the Penrose Inquiry is going on...

**RESPONDENT:** Can you imagine the amount of money they are spending and its going to come to nothing.

**INTERVIEWER:** So you don't see any value in inquiries?

**RESPONDENT:** No, no but they do that politically because it comes from a group of voters and they want to satisfy them.

**INTERVIEWER:** So I suppose in the criminal law you wouldn't see any...

**RESPONDENT:** In reality it's not going to help anything, it's not going to discover anything, its not going to tell you anything new, it's not going to identify any responsibility for anybody, it's wasted money! It would be better to put all the money they spent into this fund and when somebody has something, give them money, much simpler.

**INTERVIEWER:** Did you have any questions you wanted to? Melinee (Interviewer 2) is exploring quite a lot in her PhD so that's why I've been asking questions...

**RESPONDENT:** You have a hypothesis and things, I don't, I have no idea of a PhD in law but I assume that you have still a hypothesis and you have to find a...**1:15:02**

**INTERVIEWER:** Her PhD is really tough, there's not a lot of...

**RESPONDENT:** What is her subject?

**INTERVIEWER2:** The role of the criminal law in health care in France and England.

**RESPONDENT:** That's very general!

**INTERVIEWER:** Yes and for us in England for example that a group of injured people could bring proceedings in the criminal jurisdiction and also get compensation, that is very strange to the English legal mind and there's just not a lot of work published on it and so she's, there's a lot of work in criminal law for example but not in health care area and comparative so we're going round talking to as many people as we can to sort of get an idea. Because there's also, you read stuff in books but what happens in practice is often completely different and also we're finding in relation to the French blood contamination episode that there's a lot of what is said and then when you talk to people it just seems to be so different so we're just trying to get as many different perspectives as we can to try and make sense of it.

**RESPONDENT:** You should start with this journalist who has written a book and who is preparing another book in France, what's her name? She published a big book a couple of years ago that finishes at the end of eighty-three and then she has been

writing another book, no, no it's a journalist, a lady who is very nice, (???), you should talk to her she has become a good friend of mine and she is very good and she knows a lot and she has really a balanced approach, she is a good person to talk to and she knows everything.

**INTERVIEWER:** This is me wandering off onto a bit of a tangent now, but I'm just interested to know because you would know what is going on in England in terms of testing now, do they do NAT testing for all viruses here now?

**RESPONDENT:** For all viruses?

**INTERVIEWER:** Sorry the Triplex test?

**RESPONDENT:** Yes, it took a long time but finally they adopted the Triplex test about a year ago.

**INTERVIEWER:** About a year ago because I know we've spoken today about Hepatitis C and it was not worth it.

**RESPONDENT:** Hepatitis B, that's what I'm working on.

**INTERVIEWER:** I know you've written about it, the Triplex, general pathogen reduction testing, do you see it as the magic bullet for dealing with a range ...?

**RESPONDENT:** I do actually.

**INTERVIEWER:** Or is it written by Kleinne I think, saying this is our magic bullet?

**RESPONDENT:** It's both Harvey Klein and Harvey Alter.

**INTERVIEWER:** They seem to write together sometimes.

**RESPONDENT:** They are in the same group, in the same lab, they are both very good friends of mine.

**INTERVIEWER:** So they've simply got to take, this is our magic bullet and deal proactively with infectious diseases?

**RESPONDENT:** They are not working on it but like me, actually I have been for a little while, to me that is the future.

**INTERVIEWER:** This isn't implemented, it's obviously costly.

**RESPONDENT:** Very costly.

**INTERVIEWER:** But then would you be able to do all the other tests, Triplex, politically that would be...

**RESPONDENT:** Some, some of them not all but some of them yes.

**INTERVIEWER:** So it's a possibility?

**RESPONDENT:** Yes.

**INTERVIEWER:** Do you think politically it's a possibility though or do you just see layer upon layer upon layer of safety?

**RESPONDENT:** Yes well, yes actually it shouldn't be strictly speaking added, it should be added and withdrawing some of the current methods, because obviously it covers a lot of...

**INTERVIEWER:** I know you said you're quite involved with global safety issues as well, how active is that, is it really going places, obviously you're involved in the malaria side as well, is there enough support to get initiatives going.

**RESPONDENT:** There is a major problem which is that it's important for developing countries, for poor countries and this global consortium on blood safety which was organised between blood centres, organisations of various types and the WHO has been divorcing completely because the views of the WHO and the views of the expert group, myself being one of them are totally diverged so we decided no longer to..

**INTERVIEWER:** So you're just doing it independently? **1:20:01**

**RESPONDENT:** That's right and I think this is very unfortunate because people in the middle don't know what to believe.

**INTERVIEWER:** Because normally there would be this umbrella organisation?

**RESPONDENT:** Exactly so you know the established thing is the WHO and the WHO is doing a lot of things which are unjustified and actually counterproductive.

**INTERVIEWER:** In terms of blood safety or blood safety initiatives?

**RESPONDENT:** Blood safety, blood supply, everything so that's a very unfortunate situation which the WHO has created about two years ago so at the moment it's just sort of in limbo.

**INTERVIEWER:** I was getting excited about the initiative!

**RESPONDENT:** Yes but that's another political situation which is, everybody has to lose out of it and developing countries who should benefit from it are going to actually not benefit at all.

**INTERVIEWER:** You did say that you didn't have much time for the precautionary principle, is that because nobody seems to know what it means, certainly in the wake of all the HIV blood scandals.

**RESPONDENT:** No it's just a system that has been put together by physicians so that they can cover their back, that's all.

**INTERVIEWER:** Obviously scientists such as yourself for example are asked to somehow operationalise it after, I mean, screening tests?

**RESPONDENT:** But also it's complicated because scientists are dependent on a number of organisations to do their research so for some of them the precautionary thing is great because they can get more money for their research so they push in one direction as I said because it's their advantage and it's not necessarily reflecting the scientific reality of a given issue.

**INTERVIEWER:** In terms of your day to day work in the blood services you wouldn't see that this is a big thing really?

**RESPONDENT:** I don't have day to day work with the blood service (laughs).

**INTERVIEWER:** You probably know people in the blood services?

**RESPONDENT:** Of course I do!

**INTERVIEWER:** That's okay, I don't know if we have any more... I think that's all I had to ask I'm just checking down my list here.

**RESPONDENT:** That was a lot!

**INTERVIEWER:** Sorry! That was really insightful thanks very much I've learnt so much.

**RESPONDENT:** So who are you going to see, have you seen anybody in France?

**INTERVIEWER2:** Yes we did.

**RESPONDENT:** Who?

**INTERVIEWER2:** We saw Marchetti, a sociologist, we spoke about the role of the media and the scandal.

**INTERVIEWER:** The problem with finding people who might want to talk to us too is that so many years have gone by and it's trying to find people.

**RESPONDENT:** Talk to Laura she is really good; I think she is still in Orleans somewhere.

**INTERVIEWER:** She's written a book?

**RESPONDENT:** She wrote a book on the Gregori (inaudible) business. It's only to the end of '83 so she's been working on a second volume which would be much more relevant.

**INTERVIEWER:** Are there any other people that you think might be relevant to...?

**RESPONDENT:** In France? Francoise Barré? Nobel prize winner, my good friend but not Montagnier (inaudible) we're from the same province! Because now you know, most people have retired so the actors are gone, a number of them died.

**INTERVIEWER:** We're struggling to find anybody from the Haemophilia Society who will talk to us.

**RESPONDENT:** I told you they're amnesic!

**INTERVIEWER:** We'll keep trying anyway, I was working with another researcher at one point and they had managed to interview somebody but that was back in the early 90s when it was a ...

**RESPONDENT:** There is one guy you can contact him, who has a reasonably balanced view. His name is Gerard Mauvillain.

**INTERVIEWER:** Is he still connected to...? Sorry...?

**RESPONDENT:** His parents at least his father was vice president but he's not to talk to because he's totally unreliable and very amnesic but Gerard actually worked for a pharmaceutical company preparing blood products he was a representative for them and although he is haemophiliac himself he has a very balanced view of things from that group so as far as I can tell he's one of the very few that could give you some kind of unbiased opinion about things and actually he has been very critical of the Haemophilia Society.

**INTERVIEWER:** How do we go about finding him?

**RESPONDENT:** Ha, ha very good question I have no idea!

**INTERVIEWER:** Does he still work for the pharmaceutical company?

**RESPONDENT:** I don't know I have no idea.

**INTERVIEWER:** Well at least we got some names.

**RESPONDENT:** And in England, well most of the actors have disappeared, maybe Peter Jones, I think he's still around.

**INTERVIEWER:** There's Geoff Savidge he would always talk to you if you were doing blood research.

**RESPONDENT:** Yea, he wouldn't be the most reliable person to speak to but I think that Peter would be okay, or Chris Ludlum.

**INTERVIEWER:** I used to write off to the haemophilia directors organisation to say could I just have a look at your historical notes or something.

**RESPONDENT:** Forget it!

**INTERVIEWER:** It wasn't in so many words but that would be... so I never had much luck as a researcher when I was doing my PhD trying to get access, I'm reliant on things like the Penrose Inquiry, the Archer Inquiry.

**RESPONDENT:** You know it's all accessible through the net?

**INTERVIEWER:** Yes I just haven't, I think this interim report is fairly recent isn't it?

**RESPONDENT:** Yes I received it maybe a month ago.

**INTERVIEWER:** This is two other sociologists and myself who have got money from the Economic and Social Research Council to look at risk, safety and consent in blood services in the UK, one of my colleagues who's working on the project may approach you.

**RESPONDENT:** I know nothing about the national blood service.

**INTERVIEWER:** We won't come near you then! It's hard to track down people who want to speak to us.

**RESPONDENT:** You know, for good reason people are very cautious about these things.

**INTERVIEWER:** I understand that, we come in peace really just as researchers to find out but I can understand why.

**RESPONDENT:** Who is going to believe you?

**INTERVIEWER:** Nobody I can't be trusted at all I'm a lawyer! Well in the past! Thanks very much I know you have a conference call. It's much, much appreciated that you talked to us today.

**RESPONDENT:** Thanks okay.

**Interview ends 1:29:33**

**ORDRE NATIONAL DES MEDECINS**

**DECISIONS DES CHAMBRES DISCIPLINAIRES DE PREMIERE INSTANCE**

**(entre le 16 novembre 2006 et le 15 novembre 2007)**

\*\*\*\*\*

<b>I – DECISIONS</b>	<b>1095</b>
<b>II - ORDONNANCES</b>	<b>63</b>
<b>III - ELECTIONS</b>	<b>1</b>

\*\*\*\*\*



**A/ - SAISINES.....1.158**

1°/ Plaintes : 1.147

- Auxiliaires médicaux	5	
- Avocats		3
- Conseils départementaux		127
- CD & médecin	4	
- CD & particulier		45
- CNOM	3	
- CNOM et CD	1	
- Particulier	683	
- DDASS		5
- DRASS		1
- Organismes privés divers		22
- Médecin	189	
- Médecin & particulier	21	
- Médecin & CD		25
- Ministre		3
- Préfet de département	5	
- Procureur de la République		5

2°/ Oppositions :

7

3°/ Demandes de relèvement d'incapacité : 3

4°/ Demandes d'amnistie : 1

**I/ - DECISIONS PRISES : 1095**

- Rejet plainte	509
- Avertissement	135
- Blâme	100
- Suspensions	139
(dont avec sursis.....)	33)
. 7 jours	1
. 8 jours	4
<i>(8 jours avec sursis : 7)</i>	
. 15 jours	13
<i>(15 jours avec sursis : 5)</i>	
. 1 mois	20
<i>(1 mois avec sursis : 5)</i>	
. 2 mois	6
<i>(2 mois avec sursis : 4)</i>	
. 3 mois	22
<i>(3 mois avec sursis : 4)</i>	
<i>(4 mois avec sursis : 1)</i>	
. 6 mois	21
<i>(6 mois avec sursis : 5)</i>	
. 1 an	14
<i>(1 an avec sursis : 1)</i>	

. 18 mois		1
. 2 ans	4	

(3 ans avec sursis : 1)



**B/ - NATURE DES FAITS**

- ABUS D'ACTES ET DE PRESCRIPTIONS	2
- ACTES FICTIFS	2
- ACTES HORS COMPETENCE	2
- ANNUAIRE	4
- CABINET SECONDAIRE	6
- CERTIFICAT	84
- CERTIFICAT/ SEVICES/ SIGNALEMENT	7
- CESSION DE CABINET	2
- CHARLATANISME	5
- COMMERCIALISATION DE LA PROFESSION	1
- COMPERAGE	2
- CONDITIONS D'EXERCICE	4
- CONFRATERNITE	103
- CONTRAT	12
- COUVERTURE MEDICALE UNIVERSELLE (CMU)	3
- CUMUL D'INFRACTIONS	39
- DECONSIDERATION DE LA PROFESSION	89
- DEFAUT DE LIAISON MEDECIN TRAITANT	2
- DETOURNEMENT DE CLIENTELE	12
- DEVOIRS ENVERS MALADES	239
- DEVOIRS ENVERS ORGANISMES DE L'ORDRE	20
- DEVOIRS PROFESSIONNELS	25
- DIAGNOSTIC - ERREUR/ DIAGNOSTIC TARDIF	49
- DIVERS	12
- EXERCICE PENDANT SUSPENSION	2
- EXPERTISE	46
- FAUTE PROFESSIONNELLE	38
- GARDE	7
- HONORAIRES	15
- IMMIXTION DANS AFFAIRES DE FAMILLE	91
- INFORMATION DES MALADES/LIBRE CONSENTEMENT	16
- IVG	1
- LIBERALITES	3
- MEDECINE DE CONTROLE	16
- MEDECINE DU TRAVAIL	4
- MEDECINE FORAINE	1
- MORALITE	29
- MOTIF INCONNU	16
- NON REGLEMENT DE DETTES	6
- ORDONNANCES	2
- PLAQUE	2
- PUBLICITE	41
- QUALIFICATION/TITRES	6
- REFUS DE SE DEPLACER/REFUS DE SOINS + OMISSION DE PORTER SECOURS	36
- REMPLACEMENT	10
- SECRET PROFESSIONNEL	32
- STUPEFIANTS	2
- THERAPEUTIQUE DANGEREUSE/INADAPTEE OU NON EPROUVEE	7
- VACCINATION	3

## **II/ - ORDONNANCES : 63**

① Article R. 4126-5.....	58
- Amnistie – irrecevabilité	1
- Demande de relèvement d'incapacité – irrecevabilité	1
- Désistement	17
- Incompétence chambre	1
- Irrecevabilité - défaut de qualité	35
- Irrecevabilité – hors délai	1
- Irrecevabilité – article L. 4124-2	1
- non lieu à statuer – médecin décédé .....	1
② Article R. 4126-9 du code de la santé publique.....	5
- Transmission dossier au Président de la chambre nationale	5

## **III - ELECTIONS : 1**

### **- A - SAISINE**

- médecin	1
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### **- B – DECISION**

- Annulation élections	1
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22/12/2010

**ANNEE 2010**

**ORDRE NATIONAL DES MEDECINS**

**ACTIVITE DES CHAMBRES DISCIPLINAIRES DE PREMIERE INSTANCE**

**(entre le 16 novembre 2009 et le 15 novembre 2010)**

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<b>I – DECISIONS</b>	<b>1033</b>	
<b>II - ORDONNANCES</b>	<b>221</b>	<b>-----</b>
<b>TOTAL</b>		<b>1254</b>

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## 2 -

### A/ - SAISINES..... 1245

#### 1°/ Plaintes : 1225

- Conseils départementaux	169	
- CD & médecin	27	
- CD & particulier	60	
- CD & médecin & particulier		1
- CD & DDASS	1	
- CD & Trésor Public		2
- CNOM	4	
- CPAM		3
- DDASS ou DRASS devenue ARS		4
- Procureur de la République		2
- Médecin	315	
- Médecin & particulier		13
- Particulier		621
<i>dont : - chirurgiens-dentistes .....</i>	<i>8</i>	
<i>- auxiliaires médicaux .....</i>	<i>6</i>	
<i>- organismes privés divers .....</i>	<i>47</i>	
- Préfet de département		3

#### 2°/ Oppositions :

2

3°/ Demandes de relèvement d'incapacité : 4

4°/ Demande d'amnistie 1

5°/ Demande de révision : 1

6°/ Rectifications erreur matérielle 12



**I/ - DECISIONS PRISES : 1033**

- Rejet plainte	506	
- Avertissement	172	
- Blâme	114	
- Interdiction d'exercice	169	
(dont avec sursis.....56)		
. 7 jours	1	
. 8 jours	5	
(8 jours avec sursis : 3)		
. 14 jours	1	
. 15 jours	5	
(15 jours avec sursis : 9)		
. 1 mois	15	
(1 mois avec sursis : 19)		
. 2 mois	12	
(2 mois avec sursis : 3 )		
. 3 mois	26	
(3 mois avec sursis : 6)		
. 4 mois	2	
. 6 mois	17	
(6 mois avec sursis :8 )		
. 8 mois	1	

. 10 semaines

1

. 1 an 20

*(1 an avec sursis : 6)*

*(13 mois dont 2 fermes : 1)*

#### 4 -

. 2 ans	5	
<i>(dont 2 ans avec sursis : 1)</i>		
. 3 ans	1	
. 5 ans		1
- Radiation	17	
- Abstention de chambre de première instance		5
- Amnistie – non lieu à statuer	3	
- Irrecevabilité – défaut de plainte		4
- Incompétence de la chambre		1
- Complément d'information ou sursis à statuer		7
- Renvoi à audience ultérieure		3
- Désistement	25	
- Demande en révision- rejetée		1
- Relèvement d'incapacité - refus		3
- accord		1
- Demande de récusation – rejetée		1
- Demande d'amnistie – refus		1

### III/ - ORDONNANCES : 221

① Article R. 4126-5.....	159
- Désistement	99
- Irrecevabilité plainte – article L. 4124-2	49
- Irrecevabilité – défaut de qualité du plaignant	7
- non lieu à statuer – médecin décédé	2
- non lieu à statuer – amnistie	2
- requête en opposition – rejet	2
② Article R. 4126-9 du code de la santé publique.....	62
(Transmission dossier au Président de la chambre nationale)	

**B/ - NATURE DES FAITS**

- ABUS D'ACTES ET DE PRESCRIPTIONS	6
- ANNUAIRE	1
- CERTIFICAT	57
- CESSION DE CLIENTELE	4
- CHARLATANISME	2
- COMMERCIALISATION DE LA PROFESSION	9
- COMPERAGE	3
- CONDITIONS D'EXERCICE	2
- CONFRATERNITE	212
- CONTRAT	21
- COUVERTURE MEDICALE UNIVERSELLE (CMU)	4
- CUMUL D'INFRACTIONS	24
- DECONSIDERATION DE LA PROFESSION	127
- DETOURNEMENT DE CLIENTELE	12
- DEVOIRS ENVERS MALADES	148
- DEVOIRS ENVERS ORGANISMES DE L'ORDRE	8
- DEVOIRS ENVERS PROFESSIONS PARA-MEDICALES	3
- DEVOIRS PROFESSIONNELS	28
- DIAGNOSTIC - ERREUR/ DIAGNOSTIC TARDIF	84
- DIVERS	88
- DOSSIER MEDICAL	7
- ESTHETIQUE	14
- EUTHANASIE	3
- EXERCICE IRREGULIER	2
- EXERCICE PENDANT SUSPENSION	4
- EXPERTISE	28
- FAUTE PROFESSIONNELLE	20
- GARDE	5
- HONORAIRES/TACT ET MESURE	18
- HOSPITALISATION D'OFFICE	11
- IMMIXTION DANS AFFAIRES DE FAMILLE	70
- INFORMATION DES MALADES/LIBRE CONSENTEMENT	23
- LIQUIDATION JUDICIAIRE	3
- MEDECINE DE CONTROLE	18
- MEDECINE DU TRAVAIL	8
- MEDECINE FORAINE	1
- MORALITE	31
- MOTIF INCONNU	3
- NON REGLEMENT DE DETTES	4
- PLAQUE	3
- PUBLICITE	28
- QUALIFICATION/TITRES	7
- QUESTIONNAIRE + INSCRIPTION	2
- REFUS DE SE DEPLACER/REFUS DE SOINS + OMISSION DE PORTER SECOURS	25
- REMPLACEMENT	8
- SECRET PROFESSIONNEL	39
- SIGNALEMENTS	8
- SITES MULTIPLES	2
- STUPEFIANTS	2
- THERAPEUTIQUE DANGEREUSE/INADAPTEE OU NON EPROUVEE	14

# Professional Negligence

2011

## Criminal responsibility for medical malpractice in France

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Danielle Griffiths

Margaret Brazier

**Subject:** Negligence. **Other related subjects:** Criminal procedure

**Keywords:** Clinical negligence; Criminal liability; France; Prosecutions

### **\*P.N. 188 Introduction**

In England and Wales resort to the criminal process to address alleged medical malpractice remains rare.<sup>1</sup> In English law the scope for prosecuting health professionals for poor practice resulting in harm to patients is limited. In most cases it is only a fatal and gross error that may result in criminal charges, and as we shall see in the next section of this paper, the Crown Prosecution Service (CPS) is cautious in its approach to prosecuting cases of 'medical manslaughter'.<sup>2</sup> Patients and families who allege medical malpractice have in the past looked to claims in clinical negligence for redress. Current proposals to remove legal aid<sup>3</sup> from such claims may result in victims of medical malpractice in England seeking a criminal investigation of such malpractice more readily. They may look to France for an exemplar of a much broader role for the criminal process in holding doctors for account for clinical negligence.

Two major factors of the French criminal process are key to an understanding of criminal responsibility for medical malpractice in France. French criminal law offers a greater range of potential criminal charges in the context of personal injuries caused by negligence. Second, the victim of any such injury can choose to use the criminal process as a *partie civile* to obtain compensation for her injury, rather than bringing a civil claim analogous to a claim in tort for clinical negligence. French substantive law thus provides greater scope for prosecutions and the French criminal process creates an incentive for victims of negligence to seek criminal charges.

We look first at the evidence of the extent of the use of the criminal process in England gathered from research into files from the CPS. We note that one factor in the limited use of the criminal process on this side of the Channel is that the CPS are severely limited in the charges that can be brought. Next we outline the greater range of offences that could be charged in France in cases of injury caused by medical negligence and go on to examine the crucial role of *parties civiles* and some other parts of the French criminal process advantageous to victims of medical malpractice. We briefly explore whether in England greater use could be made of the criminal law before reflecting on whether greater resort to the criminal law on the French model would be desirable or damaging.

### **\*P.N. 189 Prosecuting medical manslaughter in England**

In 2006, Ferner and McDowell raised concerns that there was an increasing and disturbing trend to resort to the criminal justice system to address medical (mal) practice in England and Wales.<sup>4</sup> They argued that numbers of prosecutions for medical manslaughter were rising and that the CPS had an appetite for prosecuting doctors as an emotionally satisfying way of exacting retribution.<sup>5</sup> Our research sought to discover just how far there is evidence that the criminal process is becoming much more engaged in the regulation of medical (mal)

practice than before. Our results are somewhat mixed. We have found evidence of rising demands for the medical profession to be made accountable for mistakes, and it is true that cases of medical error have increasingly entered the criminal justice system. Analysis of inquest files over a 10 year period from three coroner's offices showed a threefold increase in complaints to coroners and the police about standards of medical treatment a relative had received. As a result of changes within the coronial system as well as increased recognition of medical error, the files also showed that coroners and the police are more likely to respond and pursue criminal investigations for medical manslaughter. Inquest files showed that police investigations, where a charge for medical manslaughter was considered, nearly doubled over the 10 year period.<sup>6</sup>

Medical manslaughter cases should be referred to the Special Crime and Counter Terrorism Division (SCCTD) of the CPS.<sup>7</sup> The SCCTD was established in 2005 to handle the most sensitive and complex cases across the country, including 'medical manslaughter', and to provide advice to investigating bodies such as the police and Health and Safety Executive and to other prosecutors within local CPS offices.<sup>8</sup> Decisions whether to prosecute are guided by the Code for Crown Prosecutors which sets out a two stage test. The first is whether there is sufficient evidence (defined as a realistic prospect for conviction). The second is whether prosecution is in the public interest.

The principal plank of the argument advanced by Ferner and others was that doctors are more likely to be prosecuted for medical error than they were 10 or so years ago, and that such increases are related to the CPS being more ready to proceed with a prosecution, implying a reduction in the evidential threshold.<sup>9</sup> However doubt has been cast on the reliability of such trends, particularly as the work relied on media reporting of these cases, a notoriously unreliable source.<sup>10</sup> Our data from an analysis of CPS medical manslaughter files cast further doubt on the claims of increased prosecutions or, at least, **\*P.N. 190** of the lowering of the de facto prosecution threshold.<sup>11</sup> The form, filing and storage of CPS files meant that we could not ascertain wholly reliable trends in medical manslaughter cases. However, while a rise in police and coronial investigations mean that cases are now referred more often to the CPS, analysis of prosecutorial decision making reveals that rather than that increasing any propensity to prosecute, the CPS are often limited in the charges that can be brought.

We suggest that the nature of the medical manslaughter tests and the particular circumstances in which medical manslaughter occurs make prosecutions rare. Unlike France, in England and Wales medical negligence usually only becomes a crime if negligence is gross, the patient dies and it caused or is a significant contributory factor to the death.<sup>12</sup> There is no general crime of negligently causing injury. It does not matter how serious or even reckless the error is the doctor will escape criminal liability if the patient survives, even if he is terribly disabled. For any prosecutor two major problems affect any charge of medical manslaughter, establishing that the error met the elusive concept of grossness and proving causation. We were able to review 75 closed files.<sup>13</sup> In 7 per cent of cases no decision was made, in 27 per cent no breach of duty was found, in 17 per cent negligence was found but was not considered to be gross, 44 per cent of cases lacked sufficient evidence of causation and just 5 per cent (four cases) resulted in prosecution with two convictions.<sup>14</sup>

The problems with causation should come as no surprise and the files illustrate just how far chance plays in determining if a doctor may face criminal proceedings. Despite evidence of recklessness, that is more than objective gross negligence, around 30 per cent of the cases we looked at could not proceed due to the failure to establish causation. Many victims of fatal medical negligence are at risk of death even before an error occurs, thus often making causation impossible to prove, remembering that the test in the criminal process is proof beyond reasonable doubt. For example, a nurse failed to treat an elderly woman

who had suffered a non-life threatening injury to her left foot. She progressively deteriorated due to the lack of care, despite the nurse being warned of this. Existing medical conditions meant that the cause of death was not established.<sup>15</sup> Furthermore, many medical deaths occur as a result of a chain of relatively small mistakes and the contribution of each individual is often either impossible to determine or so small that it cannot be said to be a substantial cause of death.<sup>16</sup> Even if causation could be established, some of the cases we looked at fell short of grossness but nevertheless indicated serious levels of neglect. For example, a diabetic patient, described as 'drowsy and confused', was allowed to self-administer his own insulin leading to an overdose that was a 'significant contributory factor in his death'. An expert concluded that this was negligence but not high enough to constitute grossness as there was a mitigating circumstance in that there were wider concerns about the safety of drug administration on the ward.

**\*P.N. 191** Even where causation and gross negligence has been identified, analysis of CPS decision making reveals that the CPS are often reluctant to prosecute because there is little evidence of subjective recklessness. Despite gross negligence manslaughter being in theory dependent on an objective test, prosecutors are acutely aware that juries are reluctant to prosecute a doctor unless there is overt subjective recklessness. The case law that purports to define when simple negligence becomes gross does not assist the CPS. The House of Lords in *R v Adomako*<sup>17</sup> affirmed that gross negligence manslaughter did not require any proof of subjective recklessness yet the direction from Lord Mackay that a jury must judge 'whether the extent to which the defendant's conduct departed from the proper standard of care incumbent upon him... was such that it should be judged criminal'<sup>18</sup> will to many ears indicate that some sort of subjective fault is needed. In *R (on the application of Rowley) v Director of Public Prosecutions*<sup>19</sup>, Mrs Rowley challenged the decision of the CPS not to prosecute a carer who left her disabled son unattended in the bath for 4-5 minutes resulting in the young man drowning in his bath. Counsel for Mrs Rowley argued that while subjective recklessness might help to establish the prosecution case in all other circumstances the state of mind of the proposed defendant should be irrelevant. Kennedy LJ refuted this claim. Subjective recklessness was, he said, not a pre-requisite of conviction for gross negligence manslaughter, but the defendant's state of mind was relevant and some evidence of 'criminality' or 'badness' must be proven.<sup>20</sup> Elucidating just what constitutes such badness makes the task of the CPS unenviable.

### **French criminal law and medical negligence**

Crossing the Channel we find much less reticence in the use of the criminal law to ensure accountability for medical malpractice and redress for victims. Indicating public attitudes in 1994 in France, the SOFRES<sup>21</sup> conducted a public survey asking the following question: 'If you or one of your family members were to be victim of medical negligence, would you ask that the doctor or hospital be prosecuted in addition to demanding compensation?' 71 per cent of those polled answered positively to the question.<sup>22</sup> It has been suggested that the results of this survey were representative of the French state of mind concerning medical negligence and it also explains the greater number of criminal trials in that area.<sup>23</sup>

One of the principal factors explaining the wider scope for the criminalisation of medical negligence in France is substantive criminal law which, unlike English law, includes a wide range of negligence based offences applying to all areas of life. The *Code Pénal*<sup>24</sup> provides that there is *délit*<sup>25</sup> 'in cases of recklessness, negligence, or failure to **\*P.N. 192** observe an obligation of due care or precaution imposed by any statute or regulation, where it is established that the offender has failed to show normal diligence, taking into consideration where



appropriate the nature of his role or functions, of his capacities and powers and of the means then available to him'.<sup>26</sup> We should note the very broad extent of the criminalisation of involuntary conduct in this definition, from simple negligence to recklessness.<sup>27</sup> The need for some form of subjective fault, of 'badness', is not to be found in French law.

The range of offences applicable to all forms of negligent conduct in French criminal law thus provides a platform for the criminalisation of medical negligence. In France, involuntary and negligent conduct resulting in injury is criminalised. In the hierarchy of crimes in France the most serious involuntary offence against the bodily integrity of a person in French criminal law is *homicide involontaire*, at first sight, the equivalent of the English offence of gross negligence manslaughter. However, *homicide involontaire* admits a larger scope for the criminalisation of negligence as it includes 'causing the death of another person by clumsiness, negligence, carelessness, recklessness or breach of an obligation of safety or prudence imposed by statute or regulations'.<sup>28</sup> Proof of gross negligence is not needed for the offence to be committed but may affect the level of punishment. A health professional may thus be prosecuted for *homicide involontaire* when he only committed simple negligence. *Homicide involontaire* is punished by a maximum of three years imprisonment when it resulted from simple negligence but by five years imprisonment when there is proof of *faute délibérée* (gross negligence or recklessness).<sup>29</sup> For example, the chief gynaecologist/obstetrician in a hospital was convicted of *homicide involontaire* (simple negligence) on the grounds that he had failed to check on his patient the day after she had given birth, although she showed sign of severe anaemia with tachycardia resulting in vaginal thrombus which necessitated immediate surgery.<sup>30</sup> The doctor received a suspended sentence of six months imprisonment.<sup>31</sup>

Other involuntary offences in French criminal law are offences which do not require death to result and have no obvious equivalent in English criminal law. A number of the CPS case files which we reviewed where the CPS could not prosecute because causation could not be proved for manslaughter might well fall within the ambit of French law addressing non-fatal malpractice. Crimes of negligence in France include *blessures involontaires* (involuntary wounding), *non-assistance à personne en danger* (failure to assist a person in danger) and *mise en danger délibérée d'autrui* (deliberately putting someone in danger). The same requirements as for *homicide involontaire* apply in the case of *blessures involontaires* - there is no requirement of gross negligence.<sup>32</sup> *Blessures involontaires* may be punished by two years imprisonment when they were the result of simple negligence and three years when they resulted from gross negligence or recklessness.<sup>33</sup> There are at present no statistics on the number of doctors prosecuted or convicted for criminal offences but it is said **\*P.N. 193** that *homicide* and *blessures involontaires* are often used in criminal proceedings for medical malpractice that caused bodily harm.<sup>34</sup> *Non-assistance à personne en danger* is particularly well suited for medical negligence because it acknowledges the criminalisation of omissions, as opposed to actions. The *Code Pénal* defines it as 'failing to render to a person in danger any assistance which, without risk to himself or to third parties, he could render him either by his own action, or by initiating rescue operations'.<sup>35</sup> *Non-assistance à personne en danger* is punishable by five years imprisonment.<sup>36</sup> A French doctor was convicted of *non-assistance à personne en danger* after he was asked by a witness to come and help an injured man who was bleeding profusely on the street less than 300 yards away. The accused doctor did not come to the aid of the victim himself but only told the witness to call an ambulance so that they could take the man to his house or to the hospital.<sup>37</sup> No such charge could be brought in England where no duty of rescue is recognised in law. French law gives legal force to the ethical obligation to be a Good Samaritan that in England

falls only within the jurisdiction of the General Medical Council.<sup>38</sup>

Another offence that may be invoked against medical practitioners is *mise en danger délibérée d'autrui*. However, unlike the other offences, it only admits *faute délibérée*, the equivalent of English gross negligence and recklessness. It applies in cases where there was 'direct exposure of another person to an immediate risk of death or injury likely to cause mutilation or permanent disability by the manifestly deliberate violation of a specific obligation of safety or prudence imposed by any statute or regulation'.<sup>39</sup> There is no requirement to prove actual harm to the patient. The sentence where no harm results is for one year imprisonment and a fine.<sup>40</sup> *Mise en danger délibérée d'autrui* was created mainly to criminalise dangerous conduct in the context of road traffic or health and safety at work. It is the only involuntary offence in French law that can be punished by imprisonment in the absence of proof of injury.<sup>41</sup>

If the *mise en danger délibérée* results in death or injury of a person, it becomes an aggravating circumstance of the offence.<sup>42</sup> As explained earlier, *homicide involontaire* is punished by five years imprisonment when it is aggravated by *mise en danger délibérée* and *blessures involontaires* are punished by three years when aggravated by *mise en danger délibérée*.<sup>43</sup> For example, a doctor was considered to have committed *faute délibérée* when he caused the death of a newborn child by using forceps when their use was not justified by the situation.<sup>44</sup> *Mise en danger délibérée* may be seen as akin to health and safety charges in England and corporate bodies such as hospitals and clinics might also face charges.<sup>45</sup>

**\*P.N. 194** We have noted that in England proving causation has been an obstacle to charges on medical manslaughter. In those cases where the commission of an offence in France requires proof of death or harm, in France too, the causal link between the conduct and the harm caused has to be established. French criminal courts do not admit the notion of 'loss of a chance' used in French civil courts.<sup>46</sup> However criminal courts have a broad approach to the causal link in terms of involuntary conduct, especially *homicide involontaire* or *blessures involontaires*.<sup>47</sup> They will often apply the theory of *équivalence des conditions* which provides that when several events have caused the damage, each conduct which has contributed to the realisation of the harm is treated 'in isolation as a cause'.<sup>48</sup> To a lesser extent courts also apply the theory of *causalité adéquate*, which takes into account the conduct which has the strongest causal link with the damage.<sup>49</sup> Causation is thus less difficult to establish in French criminal law.

Although French criminal law has historically allowed for much greater use of the criminal process against medical professionals for negligence, we should note that there recently has been a desire to limit the scope of criminalisation for negligence in order to avoid risk of over-criminalisation and restore a balance between criminal punishment and civil compensation.<sup>50</sup> In 2000 the *Loi Fauchon* introduced a new condition for criminalising negligence. In cases where a person did not *directly* cause the damage but only *indirectly* contributed to it, proof of gross negligence was required.<sup>51</sup> The aim of this reform was to protect persons who were remotely involved in the commission of involuntary offences and who could otherwise have been prosecuted for criminal offences. This reform was mainly targeting local government officials.<sup>52</sup> It was nevertheless specified that the aim of this reform should not be to mitigate the criminalisation of domains such as environment law, road traffic or health care.<sup>53</sup> In 2002, in France, a no-fault compensation scheme was also created to limit the use of the criminal law in medical malpractice.<sup>54</sup> Through the scheme, victims can obtain rapid and full compensation for serious medical accidents.<sup>55</sup> The level of seriousness of the accidents is determined according to the level of disability of the victim.<sup>56</sup> A regional commission assesses whether the injury is serious enough to get compensation.<sup>57</sup> The commission has six months to make a decision on the

compensation.<sup>58</sup> However, proceedings within the scheme do not exclude the possibility of prosecuting the doctor(s) allegedly responsible for the harm caused in a criminal court.<sup>59</sup>

### **\*P.N. 195 The French criminal process**

Over and above differences in substantive law, French criminal procedure plays a key role in explaining the greater use of the criminal process in the context of medical negligence. French criminal procedure contains features related to its inquisitorial form which make it easier and more advantageous for victims of negligence to choose criminal proceedings over civil or administrative proceedings.

In France, victims of alleged crime can join a *constitution de parties civiles*<sup>60</sup> to a criminal complaint.<sup>61</sup> Joining a *constitution de parties civile* launches the *Action Publique*<sup>62</sup>. Victims who have launched the *Action Publique* are called *parties civiles* because they are only parties to the civil action for compensation in the criminal process. The prosecutor in the criminal process is the *Ministère Public*.<sup>63</sup> When *parties civiles* have launched the *Action Publique* by joining a civil claim for compensation to a criminal complaint, the *juge d'instruction*<sup>64</sup> is required to investigate the case, but this does not mean that the final decision of the *juge d'instruction* or the *Ministère Public* will send the case to court.<sup>65</sup> However, it is a guarantee for *parties civiles* that the case will be investigated. This has an important impact on cases of medical negligence. Victims of alleged medical malpractice often claim that they want to understand what happened and who was responsible for their harm arguing that they use the criminal process for deterrence, prevention and transparency purposes.<sup>66</sup> The *juge d'instruction* and the police have wide powers of investigation and adapted means to examine a criminal case. The *juge d'instruction* can order any act or procedure necessary to the '*manifestation de la vérité*'.<sup>67</sup> The police can interrogate and place the suspects in custody.<sup>68</sup> The quality of the investigations conducted by the *juge d'instruction* and the police may have a great impact on cases of medical malpractice and could be part of the reason why many aggrieved patients and families choose to use criminal proceedings rather than civil proceedings.<sup>69</sup>

Joining a civil claim for compensation to a criminal complaint is also a much less costly way to obtain financial compensation.<sup>70</sup> As *parties civiles*, victims need not be concerned about access to funding for the claim. Criminal proceedings are free, the burden of proof does not rest on the victims, and recourse to a lawyer is not compulsory though strongly recommended. The lawyer's fees are then paid by the victims.<sup>71</sup> All the cost of any expert evidence and other evidence-related expenses are provided by the criminal justice system.<sup>72</sup> However, in a civil or administrative court in France, victims would have **\*P.N. 196** to provide and pay for evidence, experts and lawyers to support their claim. Because investigations are conducted by criminal courts in France, victims can escape the pain of going through the case file and all the details about their case as well as having to explain themselves in front of a court about something they have suffered. Moreover, the victims of alleged medical malpractice can obtain civil compensation from a criminal court if they have lodged a *constitution de partie civile* if it is proven that the accused has breached a civil obligation of care even if the accused is acquitted by judges.<sup>73</sup>

Criminal proceedings are also said to be faster than civil or administrative proceedings. However, it has been argued that criminal investigations can go on for quite a long time during which victims have no control, whereas in civil procedure, delays are more restricted.<sup>74</sup>

French criminal courts have a more active role in the procedure than civil courts and English criminal courts, and this has significant consequences on the examination of evidence. For instance, the president of a French criminal court

can question the defendant during the trial and make his own opinion about what was declared by the defendant. This is a crucial element especially in cases of negligence because judges, by examining the defendant's questioning and the expert reports, can decide whether it is a case of negligence, recklessness, manslaughter, voluntary or involuntary wounding, or homicide. However, even though medical practitioners can be criminalised for simple negligence, and thus the number of prosecutions might be expected to run to several thousands, French criminal courts seem to convict only the most serious failures in care.<sup>75</sup>

### **Could and should the criminal law be used more in England?**

It would seem that the most significant features of French substantive law relating to medical malpractice are that unlike in England doctors may face prosecution for causing harm short of death and in theory for negligent treatment that falls short of gross negligence. By contrast in England the doctor who is reckless and shows indifference to his patient's welfare, but causes injury short of death, has no cause to fear the criminal law. Chance dictates his fate.<sup>76</sup> This element of chance has led to calls either to abolish gross negligence manslaughter or create an offence of gross negligence causing serious bodily harm. Brazier has argued elsewhere that only recklessness should transform a civil wrong into a crime but that if recklessness can be proven, criminal liability should not depend on proof of death.<sup>77</sup> Griffiths and Sanders call for a new offence of 'medical neglect endangering life'. A series of recent scandals disclosing horrific neglect may sharpen the appetite for greater resort to the criminal law.<sup>78</sup> The Report of the Mid-Staffordshire Inquiry revealed evidence of patients left in their own excrement and urine, bed sores not treated *\*P.N. 197* and frail patients not fed.<sup>79</sup> Media reports suggested 400 vulnerable patients might have died prematurely as a result of callous neglect. But the patients were all gravely ill before admission to hospital and so proving that lack of care caused premature death was nigh on impossible.<sup>80</sup> Only one case was referred to the CPS who decided that there was insufficient evidence to prosecute.<sup>81</sup>

Before we consider whether English law should create wholly new criminal offences applicable generally or to medical malpractice in particular, let us briefly address the question of the potential to prosecute individual health professionals for a greater range of existing offences where harm is done but not fatal harm. First we note that s 127 of the Mental Health Act 1983 and s 44 of the Mental Capacity Act 2005 make it an offence to 'ill treat or wilfully neglect' any patient receiving care under the Mental Health Act or any patient who lacks mental capacity.<sup>82</sup> The latter provision embraces a broad range of patients, arguably including any patient unconscious or anaesthetized at the time when the culpable neglect occurred. Wilful neglect connotes conduct that clearly meets the threshold of 'badness' that Kennedy LJ looked for in any decision to prosecute for manslaughter.<sup>83</sup> At present prosecutions for wilful neglect seem to focus on staff and managers in care homes for the elderly and learning disabled,<sup>84</sup> but many elderly and frail patients in hospitals including some of the patients neglected in Mid Staffordshire Hospital Foundation Trust would fall within the protection offered by s 44 of the Mental Capacity Act. We would go further and endorse the view that wilful neglect would seem to be the proper business of the criminal law and should be extended to cover any patient receiving NHS care.<sup>85</sup>

One other existing offence may provide redress in extreme cases of medical malpractice where serious injury short of death is caused by reckless failures in care. Section 20 of the Offences against the Person Act 1861 provides for an offence of 'unlawfully or maliciously wounding or causing grievous bodily harm'. It is now established that conviction under s 20 does not require proof of a prior assault<sup>86</sup> and so the patient's consent to surgery or treatment will not bar prosecution for 'inflicting' serious bodily harm. Nor need intent to harm be proven. Recklessness may suffice for conviction under s 20.<sup>87</sup> Section 20 may

then already embrace the most extreme forms of medical negligence. If for example a surgeon in a tearing hurry to get back on the golf course ignored warnings from colleagues and removed the wrong kidney, we submit that prosecution under s 20 might be an option both if the patient survives or if he dies but causation looks problematic in relation to any charge of manslaughter.<sup>88</sup> The Health and Safety Executive (HSE) *\*P.N. 198* also has criminal powers to prosecute health care trusts for breaches of s 3 of the Health and Safety at Work Act 1974 and individual health care professionals under s 7 of the Act.<sup>89</sup> However currently the HSE does not, in general, investigate matters related to quality of care or clinical judgment leaving it to other bodies.<sup>90</sup>

Even within current English law there is some untapped potential to use the criminal law to ensure accountability for non-fatal injury. The strong feelings that can be generated when harm to a patient is seen to result from truly 'bad' medical negligence may prompt yet more pressure on the CPS to prosecute health professionals for malpractice and some may see the French model as one to be emulated. But we have noted that in France the trend is perhaps to use the criminal process more sparingly. Its major advantage for injured patients and their families is the ability to join claims for compensation to the criminal proceedings as *parties civiles*, something that cannot be replicated here without fundamental changes to common law procedure. The criminal process will not thus substitute for the loss of legal aid. Thus the question becomes what advantage would flow from greater use of the criminal law. Will health care be made safer? The evidence available suggests not. Safer care depends on a willingness by health professionals to acknowledge mistakes and near misses. Report after report indicates that blame cultures and fears of civil claims and disciplinary proceedings inhibits health professionals from being open about their own errors and those of colleagues.<sup>91</sup> Careful reading of almost any case relating to medical manslaughter reveals a catalogues of errors with multiple actors.<sup>92</sup> Merry and McCall Smith<sup>93</sup> contend that a distinction should be made between errors and violations. Put simplistically errors rarely engage moral culpability and are unintentional and so deterrence aimed at one person is unlikely to have any effect. Violations involve choices and deliberate wrongdoing, including unjustified risk taking. Alan Merry has said that in 'legal terms, violations may be thought of as equating to recklessness, and errors to negligence'.<sup>94</sup> French criminal law punishes both errors and violations. Imposing criminal liability for simple negligence would seem a step too far and risk the backlash that followed in New Zealand when doctors were convicted of manslaughter on the basis of simple and not gross negligence. Yet the position in England where criminal liability depends so heavily on chance is both incoherent and unjust.

The proposed removal of legal aid from clinical negligence cases would leave a vacuum of accountability for families and victims involved in medical error who are unable to obtain a conditional fee agreement. Their main form of recourse would be through the NHS complaints system which even in its changed form still has many of the existing drawbacks.<sup>95</sup> If there is a rise in complaints to the police stemming from such demands for accountability, we would suggest that the criminal law may have a greater *\*P.N. 199* role in deterring bad medical practice and ensuring quality of care. We would contend that, as in France, criminal liability for medical malpractice should not distinguish between fatal and non-fatal error. As so many cases in England fall when causation fails to be established, French criminal law is again instructive in the wider approach it takes. However unlike the case in France we would urge that only errors which engage moral culpability and recklessness should be criminal. Invoking the criminal law for negligence, be that negligence simple and gross does little to improve patient safety and may indeed have the contrary effect.



Questions still remain. What about cases which would still not engage criminal liability in England? Furthermore would it be possible to prosecute all non-fatal and reckless errors? Overstretched resources are a major reason why the HSE are not investigating individual clinical cases and this is not likely to improve in the current economic climate.<sup>96</sup> The CPS is undergoing financial cuts and an increased workload might well result in delays and a lower quality of investigation. Research has shown that families of victims of medical error most often want a simple explanation, apology and indication that lessons have been learnt.<sup>97</sup> It may therefore be more effective, both in terms of cost and accountability to ensure that such objectives are achieved before too swiftly resorting to the criminal process.

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- <sup>1.</sup> See M Brazier and A Alghrani 'Fatal medical malpractice and criminal liability' (2009) 25 PN 51.
- <sup>2.</sup> 'Medical manslaughter' is of course not a term of art or a discrete category of crime. We use the term as short hand for the prosecution of a health professional for gross negligence manslaughter.
- <sup>3.</sup> See the Legal Aid, Sentencing and Punishment of Offenders Bill Pt I and Sch 3.
- <sup>4.</sup> R Ferner and S McDowell 'Doctors charged with manslaughter in the course of medical practice 1795-2005: a literature review' (2006) 99 Journal of the Royal Society of Medicine 309; and see O Quick 'Prosecuting "Gross" Medical Negligence: Manslaughter Discretion and the Crown Prosecution Service' (2006) 33 Journal of Law and Society 421-450.
- <sup>5.</sup> Ferner and McDowell op cit at 314.
- <sup>6.</sup> Analysis of the early decision making process in cases of medical error was conducted as part of the AHRC research and examined the factors influencing the attrition of a case as it proceeded through the criminal process. A full account of our empirical studies will be found in D Griffiths and A Sanders 'The Road to the Dock: Prosecutorial Decision-Making in Medical Manslaughter Cases' in D Griffiths and A Sanders (eds), *Medicine, Crime and Society* (CUP) (forthcoming 2012).
- <sup>7.</sup> Many police forces lack experience in handling investigations into medical manslaughter and appear unaware of the need to refer cases to the SCCTD.
- <sup>8.</sup> Before April 2011 the division was known as the Special Crime Division.
- <sup>9.</sup> Ferner and McDowell, above n 5 at 314.
- <sup>10.</sup> S O'Doherty, 'Doctors and manslaughter-response from the Crown Prosecution Service' (2006) 99 J of the Royal Society of Medicine 544.
- <sup>11.</sup> Griffiths and Sanders above n 7.
- <sup>12.</sup> See Brazier and Alghrani, 'above, n 2.
- <sup>13.</sup> The cases covered a six year time period 2004-2009 and were those that the CPS could retrieve. The CPS store cases under the date a case closed so our sample does not include all cases that occurred within the six years or those that were not completed in that time period. We do not claim that the cases are a representative sample but they allowed an in depth analysis of decision making.
- <sup>14.</sup> One prosecution did not proceed as the defendant could not be extradited.
- <sup>15.</sup> See also C Dyer 'Doctor is cleared of manslaughter for prescribing penicillin to man who said he was allergic' (2008) 337 BMJ 2801.

- [16.](#) Griffiths and Sanders above n 7.
- [17.](#) [1995] 1 AC 171.
- [18.](#) At 187.
- [19.](#) [2003] EWHC 693 (Admin).
- [20.](#) *Ibid* at para 28.
- [21.](#) SOFRES (*Société française d'enquête par sondage* ) is the French public opinion polling institute
- [22.](#) G Nicolas, *La responsabilité médicale*, (Dominos Flammarion, 1996) 68.
- [23.](#) *Ibid*.
- [24.](#) The French criminal code.
- [25.](#) *Délit* is one of the categories of criminal offences under French criminal law. French criminal offences are classified according to their level of seriousness. *Crimes* are the most serious offences, *délits* are serious offences and *contraventions* are minor offences (111-1 *Code Pénal* ). *Délits* can be punished up to five years imprisonment (131-4 *Code Pénal* ).
- [26.](#) 121-3 *Code Pénal*.
- [27.](#) Assemblée Nationale, 2ème séance du 5 avril 2000, *Discussion d'une proposition de loi adoptée par le Sénat*, page 03122.
- [28.](#) 221-6 *Code Pénal*.
- [29.](#) And fines may also be imposed; 221-6.
- [30.](#) Crim., 29 juin 1999, *Bull.*, n°162.
- [31.](#) *Ibid*.
- [32.](#) 222-19 *Code Pénal*.
- [33.](#) And fines may also be imposed; 222-19.
- [34.](#) M Dauray-Fauveau, *La responsabilité pénale du médecin* (Les études hospitalières, 2003), 7
- [35.](#) 223-6 *Code Pénal*.
- [36.](#) *Ibid*.
- [37.](#) T C Nancy, 2 juin 1965.
- [38.](#) See General Medical Council *Good Medical Practice* (updated March 2009) para 11.
- [39.](#) 223-1 *Code Pénal*.
- [40.](#) *Ibid*.
- [41.](#) Assemblée Nationale, Rapport n° 2266, p 12.
- [42.](#) *Ibid* at 13.
- [43.](#) And fines may be imposed; 222-19.
- [44.](#) CA Agen, 12 September 2005.
- [45.](#) Since 1994 in France, corporations can be convicted of all criminal offences applicable to individuals. The criminalisation of corporations is not exclusive. In the same criminal proceedings, both corporations and individuals may be prosecuted and convicted. For a corporation to be criminalised, a criminal offence has to be committed by one of its bodies or representatives on its behalf; 121-2 *Code Pénal*, there are certain limits as regards to the criminalisation of *collectivités territoriales* (local authorities). B Boulloc, H. Matsopoulou, *Droit pénal général et procédure pénale* (17 ed), (Sirey, 2009) at 153; Assemblée Nationale, Rapport n° 2266.53

- [46.](#) I Jamin, 'La responsabilité pénale en milieu de soin: une préoccupation réelle, une menace relative?', *Actualité Juridique Pénal* 2009, 340.
- [47.](#) Assemblée Nationale, Rapport n° 2266, 40.
- [48.](#) JR Spencer, M-A Brajeux, 'Criminal liability for negligence - A lesson from across the Channel?'(2010) 59 *ICLQ* 12; Assemblée Nationale, Rapport n° 2266, 18
- [49.](#) Assemblée Nationale, Rapport n° 2266, 18; Spencer, and Brajeux, op cit at 12.
- [50.](#) Assemblée Nationale, Rapport n° 2266, 5, 48.
- [51.](#) 121-3; *Loi n° 2000-647 du 10 juillet 2000, tendant à préciser la définition des délits non intentionnels* (1) (JO 11 juill. 2000, p 10484).
- [52.](#) Assemblée Nationale, Rapport n° 2266, 5-6.
- [53.](#) Assemblée Nationale, Rapport n° 2266, 7.
- [54.](#) *Loi n° 2002-303 du 4 mars 2002 relative aux droits des malades et à la qualité du système de santé.*
- [55.](#) S Taylor, 'Providing Redress for Medical Accidents in France: Conflicting Aims, Effective Solutions?', (2011) 2 *JETL* 59.
- [56.](#) Taylor, op cit at 61.
- [57.](#) Taylor, op cit at 62.
- [58.](#) Jamin op cit at 340.
- [59.](#) S Taylor, 'Clinical Negligence Reform: Lessons From France?'(2003) 52 *ICLQ* 739.
- [60.](#) Civil claim for compensation.
- [61.](#) *Articles 2 et 3 Code de Procédure Pénale*; B Bouloc, H Matsopoulou, *Droit pénal général et procédure pénale* (17th ed) (Sirey,2009) 179, 197.
- [62.](#) *Action Publique* is the equivalent of a public prosecution.
- [63.](#) *Ministère Public* is the French public prosecution service.
- [64.](#) Investigating judge.
- [65.](#) Bouloc, Matsopoulou op cit at 354.
- [66.](#) D Viriot-Barrial, 'Le droit pénal face aux grandes catastrophes sanitaires', *Revue de droit sanitaire et social* 2008, 21.
- [67.](#) *Recherche de la vérité* or *manifestation de la vérité* ('search for the truth') are terms employed in French criminal procedure to indicate that investigations conducted by the *juge d'instruction* aim to gather all the information necessary to retrace the event as it really happened; *Article 81 al 1 Code de Procédure Pénale*
- [68.](#) M Daury-Fauveau, *La responsabilité pénale du médecin*, *Les études hospitalières*, 2003, 47-48.
- [69.](#) *Ibid* 48.
- [70.](#) Bouloc, Matsopoulou, 199.
- [71.](#) P Verrest, 'The French public prosecution service'(2000) 8 *European Journal of Crime, Criminal Law and Criminal Justice* 210.
- [72.](#) Daury-Fauveau, op cit, at 45.
- [73.](#) Daury-Fauveau op cit at p 46.
- [74.](#) Jamin, op cit at 340.
- [75.](#) M Veron, *Tome 3: La responsabilité pénale du médecin*, in L Melennec, *Traité de droit médical* (Maloine,



1984) 30.

- [76.](#) See the classic article by JC Smith 'The Element of Chance in Criminal Liability' [1971] Crim L R 63; and see Brazier and Alghrani,, above, n 2, at 59-63.
- [77.](#) M Brazier and N Allen 'Criminalising Medical Malpractice' in CA Erin and S Ost (eds) *The Criminal Justice System and Health Care* (OUP, 2007).
- [78.](#) Griffiths and Sanders op cit, above, n 7.
- [79.](#) *Independent Inquiry into care provided by Mid-Staffordshire NHS Foundation Trust January 2005-March 2009* HC 375-1 (The Stationery Office, London).
- [80.](#) C Wells 'Medical Manslaughter: Organisational Liability' in Griffiths and Sanders above n 7.
- [81.](#) J Bingham 'Diabetic patient died after nurses failed to give insulin injections', *The Telegraph*, 7 September 2010.
- [82.](#) N Allen 'Psychiatric Care and Criminal Prosecution' in Griffiths and Sanders above n 7.
- [83.](#) *R (on the application of Rowley) v Director of Public Prosecutions* [2003] EWHC 693 (Admin) above n 20.
- [84.](#) See N Allen in Griffiths and Sanders above n 7.
- [85.](#) See A Alghrani, M Brazier, A-M Farrell, D Griffiths and N Allen 'Healthcare scandals in the NHS: crime and punishment' (2011) *Journal of Medical Ethics* 230-232.
- [86.](#) *R v Burstow and Ireland* [1998] AC 147, HL.
- [87.](#) *R v Mowat* [1968] 1 QB 421; *R v Savage and Parmenter* [1992] AC 699, HL; for withering criticism of this line of case law see A Ashworth *Principles of Criminal Law* (6th edn) (OUP, 2009) at 300-302.
- [88.](#) For an account of an Australian case where a surgeon was convicted of recklessly causing serious bodily harm see I Dobinson 'Doctors who kill or harm their patients: the Australian Experience' in D Griffiths and A Sanders (eds) above at n 7.
- [89.](#) Prosecution of health care trusts is unusual. For the most recent case see S. Morris 'Hospital fined £100,000 after wrong drug killed new mother', *The Guardian*, 17 May 2010. For a discussion of health and safety law in health care see O Quick 'Medical Manslaughter' in Erin and Ost, above n 78, at 40. To date no individual health care professional has been prosecuted by the HSE for a clinical matter.
- [90.](#) See <http://www.hse.gov.uk/enforce/hswact/priorities.htm#clinical>.
- [91.](#) See Brazier and Alghrani above at n 2 at 63-65.
- [92.](#) See O Quick 'Medical Killing: Need for a Specific Offence' in CMV Clarkson and Sally Cunningham *Criminal Liability for Non-Aggressive Death* 155 at 171.
- [93.](#) A Merry and A McCall Smith *Errors, Medicine and the Law* (CUP, 2001).
- [94.](#) A Merry 'When Are Errors a Crime-Lessons from New Zealand' in CA Erin and S Ost above n 78 at 89.
- [95.](#) J Allsop and K. Jones 'Withering the Citizen, Managing the Consumer: Complaints in Healthcare Settings' *Social Policy and Society*, 7 (2) (2007) 233-243.
- [96.](#) <http://nhslocal.nhs.uk/story/hse-boss-points-regulatory-gap-allowed-stafford-hospital-scandal-continue>
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- [98.](#) Melinee Kazarian is a PhD candidate who carried out research in support of the AHRC funded project 'The Impact of the Criminal Process on Health Care Ethics and practice', School of Law University of Manchester. Danielle Griffiths MA(econ)PhD, is a Research Associate at the Centre for Social Ethics and Policy, School of Law University of Manchester. Margaret Brazier QC, FMed Sci, is Professor of Medical Law at the Centre for Social Ethics and Policy, School of Law University of Manchester. She was the Principal Investigator for the AHRC funded project 'The Impact of the Criminal Process on Health Care Ethics and Practice.'

