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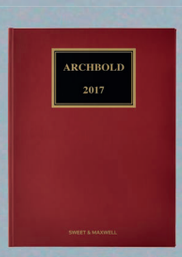

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All submission and editorial inquiries to
John Cooper, 25 Bedford Row, London, WC1R 4HD
[tel] 020 8686 9141 [email] jgcooper58@yahoo.co.uk
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Magazine Editor: Diana Rose
[email] diana.rose@lexisnexis.co.uk [tel 020 7400 2828]

Head of Display Advertising: Charlotte Scott
charlotte.scott@lexisnexis.co.uk
[tel] 020 8212 1980 [mobile] 07919 690362

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FEATURED IN THIS ISSUE

VIEW FROM THE EDITOR

Cautions

EDITOR **John Cooper QC**

Recently, the Assistant Chief Constable for Greater Manchester observed that "A Police Caution can also act as a record for possible reference in future criminal proceedings". This, of course, comes as no surprise to those who practice in the criminal justice system, and certainly as no shock to the many of us who ply our trade in the criminal courts as the prosecution often seek to introduce the caution as bad character or produce it as antecedents during the sentencing exercise.

It contains many of the attributes of a criminal conviction, right up to being a potential impediment to entry into some overseas territories and to being disclosable to potential employers. In short, it criminalises the recipient.

The reality of the Police Caution is that they are often proffered by the police during the immediate aftermath of an individual being arrested and are primarily used to deal with young people. Often, they are offered by the police to detain people who are either frightened of the circumstances that they are in, not necessarily, I add, because they are guilty, and without the evidence against them being considered by independent legal advisors for either cogency or admissibility.

Cautions obviously help police detection statistics and if properly administered and maturely considered and accepted, present a useful tool for use in the criminal justice system. But I have been taken by the overwhelming support that my simple proposal concerning cautions has received from all sides of the legal profession, a proposal which is structured to make sure that vulnerable members of the public are not bounced into a decision to accept a caution which is both wrong and destructive.

I would like to see a 30 day cooling off period for every Police Caution which is accepted without independent legal advice.

After all, as "The Secret Barrister" put it to me on Twitter, "It is ludicrous that you get better protection buying pants online than accepting a criminal record".

A happy, but cautious Christmas to all our readers. ■

QC, 25 Bedford Row. The comments made are not necessarily those of the CBA.

Educating the Public in Law

Chairman's column

Francis FitzGibbon QC

I could not have had a better predecessor as Chair of the CBA than Mark Fenhalls QC. He was vice Chair and then Chair through the dark days of 2014 and 2015, when it seemed that the profession's days were numbered. We had an unsympathetic Lord Chancellor; we were feeling the impact of heavy cuts to our fees and those of the solicitors under LASPO; in the spring of 2014 we had the "strike" when the Bar stopped doing returns; that preceded the rancorous fall-out from the agreement with the Ministry of Justice which protected our fees from further cuts; then the abortive strike in the summer of 2015, when the Bar voted to support the solicitor's action against their latest fee cut. During this period, Mark worked unstintingly to restore the Bar's frayed relationships with our sister profession, the Ministry, and the Judges, and the public, while at the same time dealing with the host of problems that our members rightly bring to the Chair's attention. I hope I was a good pupil during my year as Mark's vice Chair: he included me in all the important stuff, and taught me a great deal – I had not been active in any form of Bar politics before and had (and still have) much to learn. So I inherited a legacy of goodwill and good relationships with the other groups and individuals who make up our world. I hope I can pass it on next September to my brilliant vice Chair, Angela Rafferty QC.

My election as vice Chair (and Chair presumptive) in the summer of 2015 coincided with the CBA's vote to support the solicitors' strike. That was paradoxical, because my pitch was that the strike was unnecessary and potentially harmful. Not because I didn't sympathise with the solicitors, facing a second cut of 8.75% to their fees, but because I thought the strike would not work and there were better ways of dealing with the problem. As it turned out, the strike collapsed and the newly elected government thought better of the cut – at least temporarily. They suddenly seemed far less hostile to the profession than their predecessors had been. Michael Gove saw that the law was turning into a two-tier proposition: good for those who could pay, sub-optimal for those relying on legal aid – or fending for themselves. He didn't like what he saw, and was outspoken about it. The MoJ published an ambitious consultation paper on the quality of criminal advocacy, in October 2015. They had absorbed the criticisms and proposal for reform that had appeared in the persuasive reports by Sir Brian Leveson, Sir Bill Jeffrey, and His Honour Geoffrey Rivlin. Things could not go on as they had been.

> "I would like the Bar in general and the Criminal Bar in particular to answer the lies and smears about what we do, and why the rule of law is so important."

So when my term as Chair started, the mood was markedly different from what it had been in the previous summer. Things seem to be moving in the right direction – but at a disconcertingly slow pace. The Government has still not announced its final position on the 2015 consultation. My priorities as Chair flow from the CBA's response to it.

I want to see an end to the Byzantine complexity of the AGFS payment scheme, which distributes the limited public funds that are available in the wrong way. It is especially harsh for the more junior advocates, and turns people away from criminal practice. We need to move away from payment that is largely based on the volume of paper in a case and not on the work we actually do. One case might include thousands of "pages" (almost certainly saved on a disc) of schedules of phone contact. In the digital age page counts are obsolete. A document like a phone schedule can be searched electronically for any relevant material within seconds. No one is going to read it line by line: yet the "pages" count toward the inflated fee. On the other hand, a one-complainant rape with complicated issues of bad character, hearsay and vulnerability, which places huge demands on the advocate, may only have a few score pages, and will be paid at a rate that totally fails to represent the work that has to be done. The smaller cases and non-trial hearings that go to more junior advocates are paid appallingly, or not at all. If someone wanted to design a fee structure that made the prospect of a career at the Criminal Bar unviable for any but the moneyed or the foolhardy, this would surely be it. The future pool of senior advocates and Judges will be drained. A bad system of payments is simply not in the public interest.

The other side of the coin of fee reform, and one of the questions from the 2015 consultation that the Government has not answered, is the urgent need for panels for defence advocates. I am a believer in this. If the public is to have confidence that its money is being spent wisely on legal aid for advocates, it needs to be assured that people of the right calibre are being used. This is not so much a matter of regulation as of quality assurance for the purchaser – ultimately the taxpayer, more immediately the lay client. The hallmark must be excellence. Mere adequacy is – well, inadequate when people's livelihoods, reputation and liberty are at stake.

We need a scheme to ensure that people of the right – high – calibre go into the right work. It must apply to all criminal advocates, both solicitors and barristers. While the players in the AGFS reform are the professions and the MOJ, the defence panel scheme would bring in the judiciary and the regulators as well.

The will on the part of the Bar to make these things happen is strong. I believe that they will enhance the prospects and the reputation of all advocates, whether they are barristers or solicitors. The ambition is to restore criminal advocacy to its rightful place as the visible flagship of the legal profession, with high standards of professionalism, independence and integrity. That is – or should be – a modest, even a conservative, ambition. No one is

asking for a revolution, but the restoration of a profession that has been grievously damaged by years of demoralization, underfunding, and on occasion downright hostility. The Government need to match our ambition by continuing where they left off after the 2015 consultation.

They have invested heavily in the digitization of criminal court proceedings. I for one welcome the move away from paper to online files. I can work anywhere, from a laptop. One less good side-effect of paperless working is that it makes having a physical presence in Chambers redundant. Hence, people meet less, and there are fewer opportunities to exchange ideas and for people to get to know each other and develop the bonds and mutual support that have contributed so much to our profession's unique character. On balance, though, the abolition of paper is a great advance. The next phase, the Common Platform, is intended to link all the agencies involved in criminal justice together, so that all can communicate readily with one another.

The Digital Case System was designed to complement the Better Case Management initiative, the aim of which is to get the parties to engage with the court and each other as soon as possible, to drive out delays and to identify genuine guilty pleas at the earliest stage. It's too soon to judge how well it meets these laudable aims. As BCM develops, fewer non-essential hearings will require people to attend Court.

The people who make the strategic decision about the administration of criminal and civil justice are wedded to technological solutions to practical problems – many of which are the result of the unwillingness of government to fund the system as we have known it. I am no Luddite. When it is used wisely, technology's benefits are plain to see. Criminal law, however, is all about individual people and their interactions. There is no substitute for getting everyone in the same room, and thrashing out problems. It works. There is also a question about open justice. Too many hearings conducted by phone or online, and the public lose the opportunity to see what it being done in their name.

Which leads me on to the other big ambition I have: to educate the public about the law. Sections of the media have run a foul and mendacious campaign about the Judges hearing the Article 50 litigation; politicians have picked it up; some of the below-the-line comments and social media traffic suggest that the media are both reflecting and fuelling a wider hostility – and a wider ignorance. I would like the Bar in general and the Criminal Bar in particular to answer the lies and smears about what we do, and why the rule of law is so important. This is no new battle, but it keeps having to be refought. Here is what Lord Atkin said many years ago:

> *"How little the public realise how dependent they are for their happiness on an impartial administration of justice. I have often thought it is like oxygen in the air: they know and care nothing about it until it is withdrawn."*

If during my tenure as CBA Chair I can help the public to know and care a little more, the year will not have been a total failure. ■

Cases against the military

Preface

Exempting military actions from claims under the European Convention

Contributor

Richard Clayton QC

In early October the Government announced it would opt out of the European Convention on Human Rights (ECHR) during any future wars – to see off what the Prime Minister described as an "industry of vexatious claims" against soldiers.

This announcement is the first sign that shows how the new Government will reverse the impact of human rights in post-Brexit Britain. The proposal looks like a step too far.

The Government's new policy announcement is very different in conception from the UK's earlier attempt to derogate from Convention rights, which resulted in the famous House of Lords decision in the *Belmarsh* case in 2004. It also strongly contrasts with the Conservative Party's repudiation of the ECHR in 2014, when they trailed the idea both of renouncing the Convention and abolishing the Human Rights Act (HRA) in run in up to the last General Election.

The fate of the HRA has of course been closely linked to the Iraq War ever since the destruction of the Twin Towers in New York in September 2001. The HRA was introduced with much fanfare in 1998 as a key element to Labour new constitutional settlement, embracing devolution in Scotland, Wales and Northern Ireland and the abolition of the House of Lords. But War on Terror meant the Blair Government soon developed profound reservations about the value of human rights legislation.

New Labour's scepticism towards the HRA resulted in the Government's first attempt to derogate from human rights in 2004. According to longstanding Strasbourg decisions of the European Court of Human Rights, the absolute prohibition under 11, art.3 against torture and inhuman treatment required that suspected terrorists could not be removed from the UK – if there were substantial grounds for believing that the suspected terrorist would face torture if they were deported.

This practical problem faced New Labour with the dilemma. If suspected terrorists were indefinitely detained

without trial because they could not be deported anywhere else, that detention would breach the liberty rights guaranteed by the HRA under art.5.

As a result, as part of its ant-terrorism campaign New Labour decided to derogate from these art.5 liberty rights, both under the HRA and under the ECHR. A number of suspected terrorist who were detained without trial at Belmarsh claimed breaches of human rights, which succeeded both before the House of Lords and, even more comprehensively, before the European Court of Human Rights.

The Government was required to abandon the derogation orders and introduced the control order regime to regulate detained suspected terrorist. Following a Government Review of Counter-Terrorism and Security Measures in 2011, the Home Office then announced the scheme to replace control orders with Terrorism Prevention and Investigation Measures.

However, the Government's recent initiative to exempt the military from compensation claims has very different roots. Normally, the territorial scope of English legislation is strictly limited and domestic legislation only applies to acts and omissions that take place in England, Wales and Northern Ireland. But the position is very different under the HRA, because the territorial scope of the HRA is defined by the ECHR.

Article 1 of the ECHR binds the parties to the Convention and secures rights under the other Articles of the Convention "within their jurisdiction". However, in exceptional cases, the obligation to secure Convention rights can also extend to foreign territory, such as occupied land in which the State exercises effective control.

The precise meaning and scope of the ECHR's extra-territorial jurisdiction is very controversial and has been the subject of many Strasbourg, House of Lords and Supreme Court decisions.

The extended scope to bring human rights cases has led to a number of high profile Iraq war cases which have provoked considerable controversy, none more than the Al Sweady litigation. On May 14, 2004 soldiers from the Argyll and Sutherland Highlanders and the Princess of Wales Royal Regiment were ambushed by Iraqi insurgents, leading to a three-hour gun battle, which included the use of bayonets. It became known as the "Battle of Danny Boy" – named after a British checkpoint near the town of Majar al-Kabir in southern Iraq.

After the battle, an order was issued to take the bodies of dead Iraqis to a nearby military base, Camp Abu Naji. The British Army said it wanted to check whether one of the dead was an insurgent thought to have been involved in the killing of six Royal Military Police officers in 2003. They claimed that nine Iraqi men were also taken captive and they all stayed alive.

However, lawyers for the families of Iraqis claimed others were taken alive, murdered and mutilated – although those claims, denied by the Ministry of Defence, British troops and their lawyers, were later dropped.

In judicial review proceedings brought before the High Court in 2009, Khuder Al-Sweady, an Iraqi national, claimed that his 19-year-old nephew, Hamid Al-Sweady, was unlawfully killed while in the custody of British troops at Camp Abu Naji. Five of the nine men taken captive by the army also alleged in the judicial review that they were mistreated by British soldiers while in custody at Camp Abu Naji and when later detained – for about five months – at Shaibah Logistics Base.

The Ministry of Defence faced fierce criticism from the High Court during the action brought by the Iraqis. Judges said disclosure of documents related to the claims of abuse and unlawful killings had been "lamentable" and this prompted the then Defence Secretary Bob Ainsworth to announce an inquiry to look at the allegations.

Retired High Court Judge, Sir Thayne Forbes, who oversaw the trial of serial killer Dr Harold Shipman, was appointed as the inquiry chair. The first stage of the inquiry, which searched for relevant documentation and other materials, began in 2010. Oral hearings began in March 2013, with evidence from Iraqi witnesses being heard from March to July. More than 600 military personnel and about 100 Iraqi witness statements were obtained and had searched through thousands of files of paper and digital material.

In December 2014, Sir Thayne decided that the allegations of murder and torture made against British soldiers by Iraqi detainees were "deliberate lies". The claims that up to 20 Iraqis were killed and mutilated after a 2004 battle were "reckless speculation". The murder allegations were withdrawn from the inquiry earlier this year. The report also found British soldiers mistreated nine Iraqi detainees, but this did not amount to deliberate ill-treatment.

As a result, the Solicitors Regulatory Authority is taking disciplinary charges against the two leading firms doing Iraq war compensation cases. Leigh Day and Public Interest Lawyers have been accused of shredding documents, improperly holding a press conference to demand a public inquiry and touting for clients.

The Government has responded by arguing that fighting cases against the military have cost more than £100m. So the Government now wants to make the military immune from compensation claims – by derogating (or exempting them) from the ECHR. The UK would not be the first nation to take this step. Ukraine gave notice of a derogation in June 2015, in relation to the fighting on its border with Russia. France signalled it would derogate in the immediate aftermath of the jihadist massacres at the Bataclan nightclub in Paris in November 2015. Turkey lodged a similar notice following the failed military coup in July 2016.

But taking such drastic action is very difficult to justify. The Ministry of Defence has already paid out £20m in compensation to victims of abuse in Iraq in a total of 326 cases. Those figures, alone, suggest that there is problem that needs to be addressed. The rationale for derogation in these circumstances from the Convention is, therefore, far from convincing. Exempting the military for taking responsibility for Convention rights looks like throwing the baby out with the bathwater. ■

Richard Clayton QC, Kings Chambers. He is joint author of the *Law of Human Rights* (Oxford).

Mandatory Reporting of Child Abuse and Neglect?

Preface

Mandatory reporting of Female Genital Mutilation (FGM) was introduced over a year ago – are there any lessons for Government to learn in considering mandatory reporting of child abuse and neglect?

Contributor

Neelam Sarkaria

There is currently no obligation for anyone in the UK working in a regulated activity to report the fact that they have witnessed child abuse or neglect.

A recent government consultation "Reporting and acting on child abuse and neglect consultation", which ran from July 21, 2016 to October 13, 2016 sought views on the possible introduction of mandatory reporting of child abuse and neglect or a duty to act in relation to child abuse or neglect. Prompted by the raft of institutional abuse cases where professionals turned a blind eye and did not report their suspicions the consultation has considered whether a requirement for certain organisations and employees working with children should be obliged to report child abuse or neglect if they knew or had reasonable grounds to suspect that it is taking place. The Government is still considering the consultation outcomes and a response is outstanding.

Should mandatory reporting of child abuse or neglect be introduced or a duty to act, lessons can be learned from the mandatory reporting of FGM by regulated professionals extending to teachers, social care workers and healthcare professionals working in England and Wales from October 31, 2015.

The Deputy National Policing lead for FGM, Forced Marriage and Honour-Based Abuse in England and Wales has acknowledged this:

> "It is critical that regulated professionals discharge their required duties of reporting and safeguarding in a timely way and work together with the police service and affected communities as partners to achieve the sustained prevention of FGM and other harmful traditional practices. The development of a trusted coalition partners to prevent and tackle harmful traditional practices is mission critical."

Mandatory Reporting of FGM

Section 74 Serious Crime Act 2015 (which received Royal Assent on March 3, 2015) introduced a new s.5B in the Female Genital Mutilation Act 2003. This places a single personal mandatory reporting duty on persons who work in a "regulated profession" in England and Wales. Healthcare professionals, teachers and social care workers are required to notify the police within one month, when, in the course of their work, they discover that an act of FGM appears to have been carried out on a girl who is under 18. The term "discover" includes where the victim discloses to the professional that she has been subject to FGM, or where the professional observes the physical signs of what they suspect to be FGM.

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The duty does not apply to girls or women who might be at risk of FGM or cases where professionals discover a woman who is 18 years or over is the victim of FGM.

Confining the personal mandatory reporting duty to under 18s does not prohibit appropriate referral of cases involving adults and, in particular, vulnerable adults.

Some confusion has emerged for example with the duty to collect data. General Practitioners, Mental Health Trusts and Acute Trusts (a required duty by NHS England since July 1, 2015), Sexual health and GUM (Genito-Urinary Medicine) clinics in England are required to have regard to the FGM Enhanced dataset standard from October 2015. Those services where patients do not have to provide their personal information are out of scope.

The data collected is sent to the Health and Social Care Information Centre (HSCIC), where it is anonymised, analysed and published in aggregate form. Personal information is only collected as part of the FGM Enhanced dataset for internal data quality assurance and to avoid duplicate counting. A woman or child's personal details will never be published in the national aggregate reports and will never be passed to anyone outside HSCIC. This work specifically will not pass any personal details to the police or social services, so the collection of this data will not trigger an individual criminal investigation.

The Challenges

The absence of training of health, social care and education professionals prior to the introduction of mandatory reporting of FGM is evident as regulated professionals falling within this new legislative requirement remain nervous about the fit of this duty with their existing responsibilities. Mandatory reporting is a personal duty attached to the regulated professional involved and does not apply to the organisation they work within or the department. This duty is in addition to the Recording Duty (in England only) and to their wider professional safeguarding responsibilities. Where a disclosure of FGM is made, or the professional observes the physical signs of FGM, it is their duty to report this to the police through the agreed national process.

The recent Home Affairs Select Committee (HASC) on FGM reporting on September 15, 2016 has highlighted the concern of healthcare professionals:

> "Since October 31, 2015 healthcare professionals, social care workers and teachers in England and Wales have been required to report cases of FGM in under-18s to the police. Some clinicians have raised concerns that mandatory reporting breaches fundamental principles of patient confidentiality which might result in women being less likely to speak with doctors openly. We heard that some healthcare professionals just did not accept that mandatory reporting should be their responsibility".

The legislation requires the regulated professionals (as previously described) to report the matter to the police force, which covers the victim's home address – within one month – so as to align future action with social care services in the same area. The procedural position in relation to "suspected" and "at risk" cases of FGM will remain the same. Professionals are still expected to refer cases appropriately, as set out in the multi-agency guidelines on FGM and using the existing safeguarding framework and procedures.

If mandatory reporting of child abuse or neglect were to be introduced in England, reports would be made to local authority children's social care. The introduction of a duty to act would impose a legal requirement on certain groups, professionals or organisations to take appropriate action where they know or suspect that a child is suffering, or is at risk of suffering, abuse or neglect. This option was developed following consideration of an extension of the existing wilful neglect offences – which apply in relation to healthcare and adult social care – to child abuse and neglect. The duty to act applies the same principles as wilful neglect, but is specifically focused on the protection of children rather than the provision of health and adult social care services. It would cover a broader range of behaviours and practitioners/organisations than wilful neglect and would provide a more comprehensive response to the institutional failures we have seen in Rotherham and elsewhere.

Mandatory Reporting does not replace general safeguarding responsibilities: professionals must still undertake any safeguarding actions as required, usually beginning with a

discussion with their local safeguarding lead to identify an appropriate course of action. The Department of Health's has produced guidance to assist professionals *Female Genital Mutilation Risk and Safeguarding: Guidance for professionals* (2015) as has the Home Office *Mandatory Reporting of Female Genital Mutilation – procedural information*.

Mandatory reports of FGM should be made in accordance with the nationally agreed reporting mechanism to the police. A longer timeframe may only be appropriate in exceptional cases where a professional is concerned that a report to the police may result in an immediate safeguarding risk to the child and considers that consultation with colleagues or other agencies is necessary prior to the report being made. The regulated professional is required to note the reasons for the delay in reporting and ensure that this is drawn to the attention of their manager. Information including the name of the complainant and name, address, date of birth and the nature of the discovery should be reported to the police.

Breaches of the FGM mandatory duty will be dealt with by the relevant regulatory body disciplinary process taking into account all factors. Recording the reasons for not reporting FGM is therefore critical.

In its response to a previous HASC report, the Government rejected the recommendation that sanctions should range from "compulsory training to a criminal offence for intentional or repeated failures" and said that failure to comply with the mandatory reporting duty would be dealt with in accordance with existing disciplinary procedures. The 2016 HASC Report "female genital mutilation – abuse unchecked" has however reiterated:

> "Existing disciplinary procedures for professionals who ignore the duty on mandatory reporting are insufficient and ineffective and it is unacceptable that some clinicians appear to refuse to accept it as their responsibility. The duty to report must not be seen as optional. A decision not to report puts children's lives at risk and is complicit in a crime being committed. We repeat our predecessor Committee's recommendation that the Government introduce stronger sanctions for failure to meet the mandatory reporting responsibility, beyond the relevant professions' own general disciplinary procedures".

When a mandatory report of FGM is made, the police will then work with the relevant agencies, notably Children Social Care to determine the most appropriate response. The primary focus of the duty is on safeguarding girls and women. The police will investigate the matter and where it is suspected that a criminal offence has been committed, the regulated professional who reported the matter may be required to make a statement to the police to assess whether any criminal charges should follow. Where an offender is subsequently charged with a criminal offence and does not accept their guilt, a trial is likely to take place. The regulated professional may be required to attend court and give evidence.

Mandatory Reporting Data

Should mandatory reporting of child abuse or neglect or a duty to act in relation to child abuse or neglect provision will need to be made for the collection of data. Data presented to the Committee by Detective Chief Superintendent Gerry Campbell (Deputy National Lead for FGM, Forced Marriage and Honour-Based Abuse) confirmed that since October 31, 2015 there had been in excess of 152 referrals from regulated professionals, notably from health, education and from children's social care. However, those figures were not comprehensive as some forces had not yet returned data. He noted that one police force in particular (not named) had received a significant number of reports from professionals that could offer lessons for other force areas in maximising reporting.

Data collection following FGM mandatory reporting remains an issue and the HASC has recommended that a centralised system for pooling reports of FGM would also be a positive step and would aid data analysis from which examples of best practice could be drawn.

> "We recommend that the FGM Unit publish quarterly reports showing high-level results, progress in police investigations and examples of best practice that should then be disseminated to all professionals with a mandatory duty to report FGM to further empower and reassure professionals. Ideally those reports should also incorporate the data collated by the Health and Social Care Information Centre to encourage improving the standards of that data but also reassure health care professionals as to how this anonymized data is going to be used".

The Future

Advance training and awareness of responsibilities for regulated professionals subject to mandatory reporting or a duty to act is key as is a need to collect accurate information detailing the outcomes – whether child abuse, neglect or FGM. Key lessons can be learned from the implementation of mandatory reporting of FGM. The recommendation regarding data collection made by the Home Affairs Select Committee on FGM must be actioned and applies equally to child abuse and neglect:

> "We were surprised and disappointed that there still appears to be no central Government office collating data on the mandatory reporting of FGM. One way to encourage reporting would be to publish readily available statistics so that those reporting can see the results of their diligence as well as that of their colleagues across the health, social care and education sectors. A centralised system for pooling reports of FGM would also be a positive step and would aid data analysis from which examples of best practice could be drawn. We recommend that the FGM Unit publish quarterly reports showing high-level results, progress in police investigations and examples of best practice that should then be disseminated to all professionals with a mandatory duty to report FGM. Ideally those reports should incorporate the data collated by the Health and Social Care Information Centre to encourage the standard of that data also to be improved. (Paragraph 49)."

Data collection is critical in highlighting whether children are being safeguarded and protected. ■

Barrister. Chair of the Association of Women Barristers.

Blame Culture

Preface
Medical manslaughter charges

Contributor
Anthony Metzer QC

On February 15, 2012, a Boots Optometrist Ms Honey Rose conducted a routine eye test for eight year–old Vincent 'Vinnie' Barker. Vinnie Barker sadly passed away on July 13, 2012 from hydrocephalus. Ms Rose was prosecuted for "gross negligence manslaughter" on the basis that she had not considered photographs of the child that showed swelling to the eye and had therefore not made an urgent referral five months before his tragic death. Ms Rose was subsequently convicted and sentenced to a two year suspended sentence on August 27, 2016.

Subsequently, Dr David Nicholl, a Consultant Neurologist based in City Hospital, Birmingham, released a petition and an "Open letter to the Academy of Medical Royal Colleges and Department of Justice" calling for a review of pursuing "gross negligence manslaughter" charges against healthcare workers. At the time of writing, the petition has over 4,000 signatures. Chief amongst Dr Nicholl's concerns is the impact on the duty of candour.

This article considers extent to which a perceived rise in prosecutions for gross negligence manslaughter on healthcare workers or "medical manslaughter" "will set back years of effort to encourage transparency when things go wrong with healthcare".

Following Francis Report: Recommendations to Prosecute and the Duty of Candour

In the wake of the Public Inquiry into the events at Mid Staffordshire NHS Foundation Trust, the Francis Report recommended that "where serious harm or death has resulted to a patient as a result of a breach of the fundamental standards, criminal liability should follow." Prosecution was recommended as part of a systematic package to deal with and deter particularly poor healthcare provision.

However, it may be that prosecution in this area is but a blunt tool. There are few offences available, and their application appears arbitrary.

Where a patient has been injured or neglected through malpractice, offences of "ill treatment" or "wilful neglect" are only available in limited circumstances. For example, where the patient is being treated or cared for as a result of a mental disorder, is under 16, or lacks mental capacity.

Although there is criminal sanction for those companies and organisations where manslaughter is a result of serious management failures leading to a gross breach of a duty of

care, cases are vanishingly few. There have been no successful medical corporate manslaughter prosecutions to date. In January 2016, in the first prosecution of an NHS Trust since the offence came into force in 2008, Maidstone and Tunbridge Wells NHS Trust were acquitted of corporate manslaughter.

One of the important recommendations contained in the Francis Report is the provision of a statutory duty of candour to apply to NHS service providers, to complement those already in place. Providers are now required to inform patients and explain if they believed that treatment provided had caused death or serious injury. Although the statutory duty does not apply to individuals, the Care Quality Commission that regulates compliance requires all staff to co-operate with the provider to ensure that the obligation is met.

A Realistic Concern: The Impact of Medical Manslaughter Charges on the Duty of Candour

There is a perceived increase in the number of medical manslaughter cases. The *Honey Rose* trial is believed to have concerned the first case of an optometrist causing a single catastrophic error. There were seven reported prosecutions between 1867 and 1989, 17 between 1990 and 1999 and 38 between 1995 and 2005. However, the average annual number of medical manslaughter cases brought remains between one and four.

The complexity of the offence is a significant factor in the limited number of prosecutions. In the leading case of *R. v. Adomako,* the House of Lords held that the jury must consider:

(1) whether the D was in breach of a duty of care towards the V;
(2) If so, whether the breach caused the death of V;
(3) and if so, whether, having regard to the risk of death involved, the conduct of a defendant was so bad in the circumstances as to amount to a criminal act or omission. The jury must consider whether D acted in accordance with practice accepted by a responsible body of medical men skilled in that specialism. It is very far from clear how a breach can become "so bad" as to be criminal. What is left is, arguably, an arbitrary application of the offence and consideration by a jury.

Further contributing factors include practical difficulties identifying these kind of cases; evidential challenges including reliance on expert evidence to prove causation; and perception difficulties where the healthcare worker was only trying to do their job in a pressurised environment and has no intention or interest in committing the breach. The author awaits a retrial where this particular concern is at the heart of the case.

Given the factors set out, the utility of such prosecutions has been repeatedly queried in the academic literature, and with some force.

What Impact on the Important Duty of Candour?

Healthcare workers are subject to the duty from various sources. The General Medical Council requires registrants to "explain fully and promptly' matters to patients where that patient has suffered harm or distress." Additionally, NHS service providers have a contractual duty to support and inform a service user of all relevant information in relation to an incident that caused moderate to severe harm or death. A healthcare worker could be disciplined and lose their job and ability to continue to practice if they fail to comply. Of course the duty of candour is important for the continued improvement of services. However, when a healthcare worker faces not just the loss of their job, but the loss of their liberty in the face of an arbitrary but serious offence, it is not hard to see that a healthcare worker may worry for self-incrimination. It raises the distinct possibility of a "blame culture."

This very issue has been highlighted before Parliament recently. In April 2016, the Healthcare Safety Investigation Branch (HSIB) was declared operational. This independent body was set up to investigate failings of care in the NHS, with a view to expert medical examiners to independently review and confirm the cause of all hospital deaths from April 2018. The Parliamentary and Health Service Ombudsman (PHSO) recommends that a "safe space principle" providing legal protection to those providing information to HSIB would be given a statutory basis. The idea is to ensure that informants, would be immune from loss of employment and the information given would be protected from Freedom of Information Act Requests, and, significantly, criminal or regulatory proceedings, except where specifically overridden due to "public interest or legal compulsion". In order to use any material disclosed to the HSIB, therefore, an application for specific disclosure would need to be made. The extent to which orders for disclosure will be made will be an interesting development to watch. It is hoped that robust protection is implemented.

Conclusion

The Francis Report recommended prosecution as a last resort in cases where serious harm or death had occurred as a result of the failure of healthcare workers during their care provision. Medical manslaughter remains one of the very few criminal sanctions applicable in this sphere. A duty of candour has been enacted which complements other forms of the duty imposed on healthcare workers.

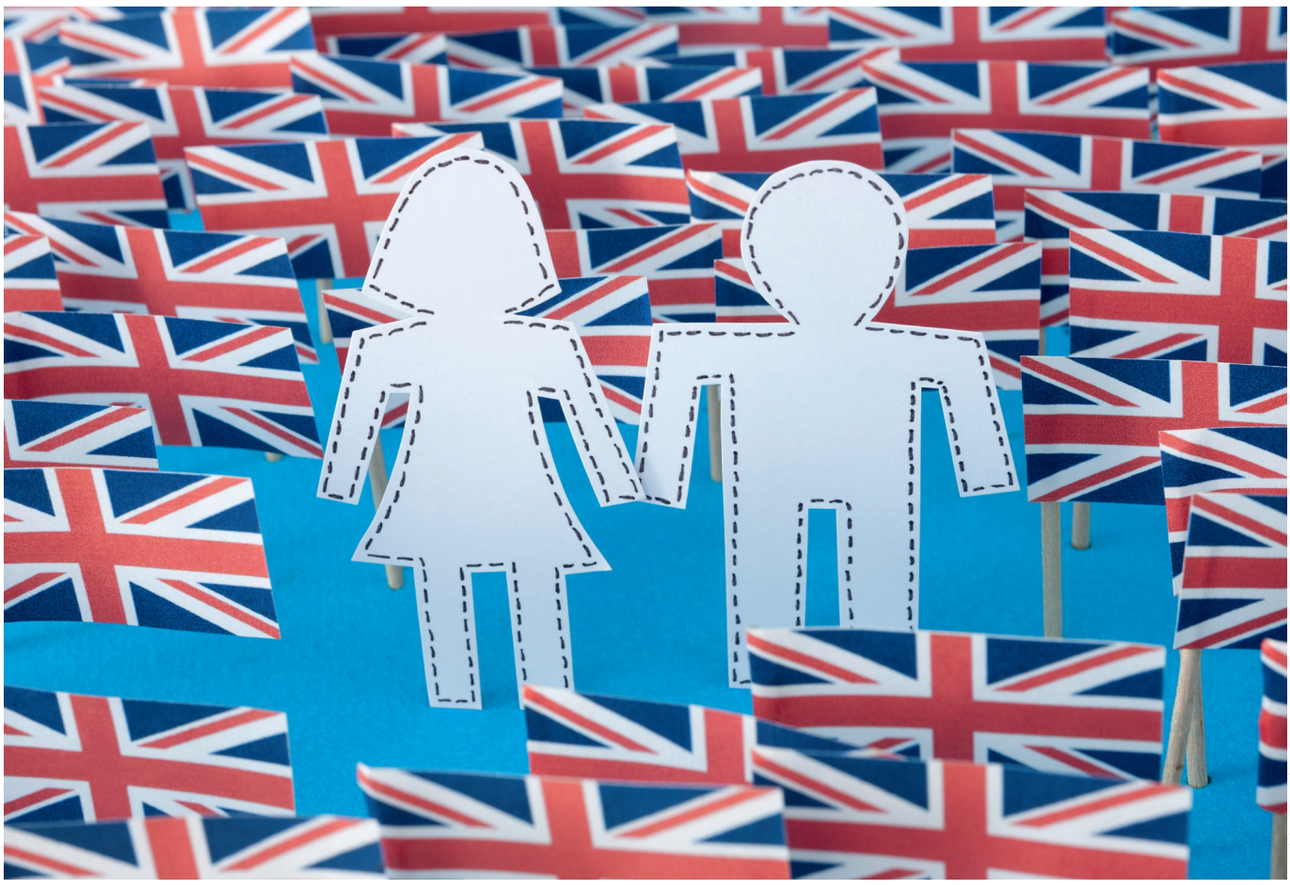
Following the *Honey Rose* trial, concerns within the healthcare profession have been raised that the pursuit of medical manslaughter charges seriously undermines the duty of candour. In circumstances where the offence and its application has been infrequent and perhaps, arbitrary, a perception that there has been a rise in these prosecutions gives credence to these concerns.

The utility of the offence as a means of regulating conduct, improving services and encouraging transparency is queried.

It is interesting to note that a "safe space principle" has been considered necessary by PHSO for the investigations undertaken by the new HSIB. In order to encourage healthcare workers to report concerns, it is proposed that the information will be protected from disclosure without court order. It is submitted that robust protections are required in order to combat understandable concerns as to self-incrimination and to prevent a "blame culture" from developing further within the healthcare service. However, it will be interesting to see how the courts will treat applications for the protected information in due course. ■

Anthony Metzer QC. Goldsmiths Chambers.

Missing Rights



Preface

The family of missing persons are not considered specifically in the Code of Practice for victims of crime

Contributor

Ian Brownhill

The National Crime Agency have recorded that 96% of missing person incidents result in persons returning home safely. And of that number, 79% of incidents are resolved with people being located within 24 hours.

The difficulty falls were people do not return home quickly, or at all. In the agony which follows it is difficult to understand the factual landscape in which a loved one has gone missing. But perhaps more difficult to understand is the legal landscape.

Paragraph 23 of the Ministry of Justice's Code of Practice for Victims of Crime guarantees that the close relatives of deceased persons are entitled to receive services under the code as victims of the most serious crime. Of course to access those rights, the family members have to prove that someone has indeed died. Without a body that is very difficult indeed. The family of missing persons are not considered specifically in the Code of Practice at all.

The same difficulty arises when the families of missing persons seeks assistance, without a body, from the Coroner. To begin an inquest into the death of a person without a body it is necessary to have the permission of the Chief Coroner and for the Coroner to have reason to believe that there has been a death in her jurisdiction and that the body has been lost, destroyed or otherwise is absent. Coroners and Justice Act 2009 s.1(4).

Again, without the body, how does the family of a missing person begin to convince the Coroner that there might have been a death in their jurisdiction? The obvious frustration is where those cases go cold. How can a family maintain the impetus of an investigation and the priority of their loved one being found?

The Missing Persons Bureau

The Missing Persons Bureau, which is part of the National Crime Agency, encourages loved ones to timetable follow up calls to investigators, but not necessarily expect information in return.

But there are no guarantees to family members of missing persons, there appears to be no minimum standard of service which these families can expect, or seek to rely upon. Instead it is simply the general statement of duty in the common law: police officers owe to the public a duty to enforce the criminal law. Fail to enforce the law and they may of course face judicial review and the prospect of a discretionary remedy including a mandatory order. However, there is no doubt that the High Court has given a very wide discretion to Chief Constables about how they go about detecting and preventing crime in their jurisdictions.

> "There is no doubt that the High Court has given a very wide discretion to Chief Constables about how they go about detecting and preventing crime in their jurisdictions."

Family members of the missing have had some success in using the European Convention on Human Rights. Even without a body, if it can be inferred that a person has died during contact with the State then the investigative duty under art.2 of the ECHR arises.

The procedural requirement of art.2 evidently gives the opportunity for the family of missing persons to benefit from an investigation. But to engage that powerful procedural requirement one needs an inference that the person died during contact with the State. Simply having evidence a person might have been killed is not sufficient.

So whilst the Presumption of Death Act 2013 has made it easier to manage the affairs of a person who is missing, it does not guarantee rights for the families of missing persons as to investigative standards or quality. Nor are such rights guaranteed by the various codes of practice, nor even sadly has art.2 been used to guarantee a minimum investigative standard into long-term missing persons.

The hope then must be that the media keep investigative impetus in individual cases. The only solution is in Parliament and probably in the All-Party Parliamentary Group for Runaway and Missing Children and Adults.

Until specific guidance is produced as to minimum expectations or rights to be enjoyed by families it seems likely that any judicial review of individual policing tactics or allocation of resources would be difficult.

(This was first published in the *CL&J*). ■

Barrister at No5 Chambers based in their London Office and is honorary legal advisor to the Find Ben Needham and Find Damien Nettles campaigns.

BFI London Film Festival 2016

'A United Kingdom' premiere and Opening Gala, 60th BFI London Film Festival, UK - 05 Oct 2016 [Left] Amma Asante [Centre] David Oyelowo [Right] Rosamund Pike

This year's BFI London Film Festival celebrated its 60th year and showcased 380 features and shorts from 74 countries.

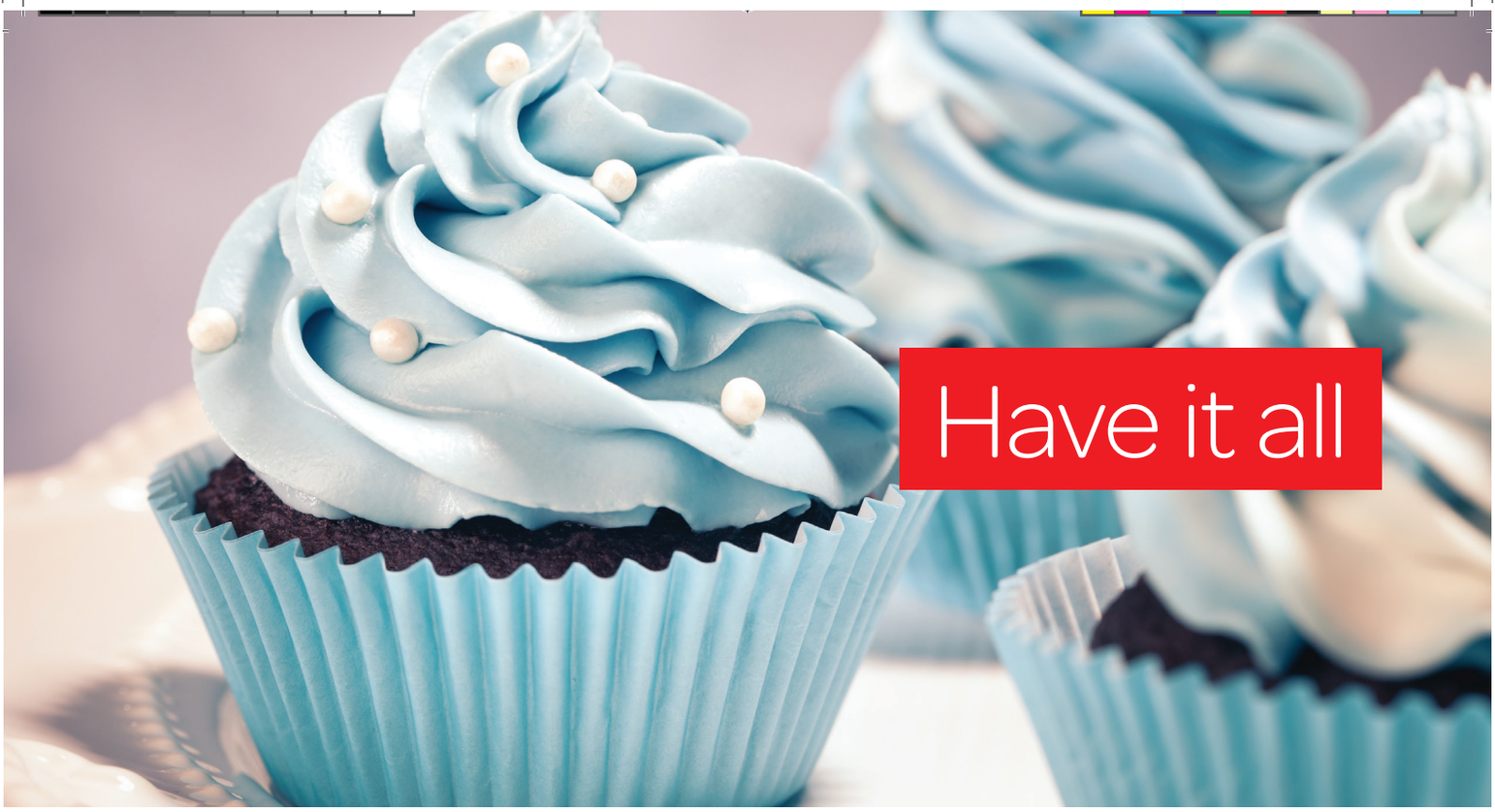
The movies on display will inevitably hit the big screens around the country and there are a number which you should look out for. Not least of all is the film which opened the Festival, *A United Kingdom*, which, in essence dealt with a love story between a white London office worker and the King of Bechuanaland, modern day Botswana. They married in 1948 and the plot exposes the chronic racism within British society at the time, right up to the highest levels of government.

The film is set within the latter days of British Imperialism and the flourishing of Apartheid in South Africa which combines to cause a diplomatic crisis over the marriage. It is a film about intolerance and prejudice and chimes perfectly with the state of Britain today and the "closed border" mentality. Rosamund Pike gives another powerful and nuanced performance of intelligence and integrity and David Oyelowo as the King combines dignity and tenacity in a multi layered depiction of his character.

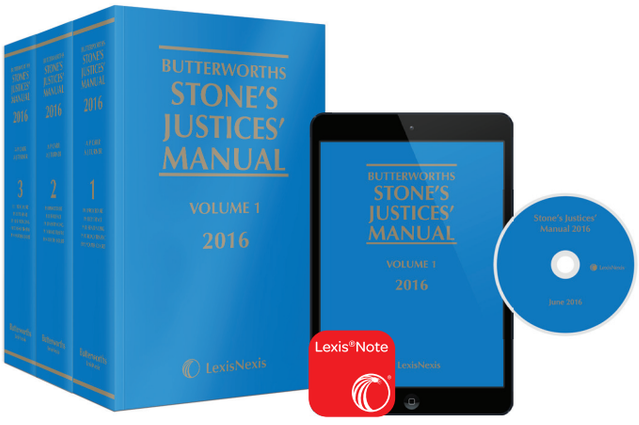
The subject of racial intolerance is picked up in the monumental *The Birth of a Nation*, a film destined to garner accolades in the months to come. This is the account of the life of Nat Turner, an enslaved African-American and ordained preacher who led a slave revolt in Virginia in 1831. He had been forced to preach submission to slaves by the slave owners but the more he sees and personally experiences abuse and atrocities of the slave owners, the more he sees it as his calling to orchestrate the rebellion. The film has many resonances to the Black Lives Matter movement in America, and like the previous film, plugs into modern concerns over racism at the very heart of society.

All this is brought together in Ava DuVernay's titanic attack upon institutional racism in The 13th. Similarly having resonances of the Black Lives Matter movement and more widely, social intolerance, this documentary reminds us that the 13th Amendment, brought in to abolish slavery and providing that neither slavery or involuntary servitude, except as punishment for a crime for which the person has been duly convicted, shall exist in America. Fine words, but by the end of this searing dissection it is clear that modern day America is served by a criminal justice system which is riddled with racism. The movie which opens with Barack Obama's words that America has almost 5% of the world's population and 25% of the world's prisoners is made particularly uncomfortable when it becomes clear that African-Americans represent a disproportionate number of those 25%.

The BFI London Film Festival is always a barometer of world opinion about what concerns us, excites us and inspires us. The films chosen are a snap shot of the public consciousness. This year it is painfully obvious that public intolerance and disintegration and the poisonous elements of prejudice and distrust are high on the agenda ■ JCQC



Stone's Justices' Manual 2016



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