‘The Impact of the Criminal Process on Health Care Ethics and Practice’ was an £860,000 AHRC-funded project led by the University of Manchester. A major strand of the project involved exploring medical error and the criminal process, in particular the prosecution of health care professionals for what is termed ‘medical manslaughter’. The AHRC subsequently awarded Follow-on Funding for impact and engagement activity.
Cooperation was gained from these organisations prior to the commencement of the follow-on project and all provided input in defining the scope of the project.

From the outset the team worked with organisations including the Crown Prosecution Service (CPS), Health and Safety Executive (HSE) and selected coroners. In pursuing policy influence we sought to ensure that the organisations perceived themselves as working with the research team, not simply as objects of research.

We invited them and, later, other public servants to most of the project events – even those that did not directly address the research relating to their specific functions. This was integral to setting up a positive relationship and building trust.

Our findings were to some extent critical of the organisations we worked with but we note that the organisations themselves were already highly self-critical. The CPS, HSE, police and coroners were all keen to address the discrepancies we identified. The research also identified other organisations with whom it was important to work if the research was to have practical effect.

We used Follow-on Funding to develop a more formal partnership with organisations involved in the investigation of medical errors, in order to address the identified discrepancies and enable a more consistent and effective treatment of these cases. These included the police, INQUEST, coroners and the HSE. Alongside these formal arrangements we also continued to work with the CPS, whose policy prevents them entering into formal partnerships. Cooperation was gained from these organisations prior to the commencement of the follow-on project and all provided input in defining the scope of the project.

The project began with several meetings with our partner organisations (and the CPS), to evaluate our previous findings and co-produce recommendations for improving consistency and effectiveness of investigations. We also conducted meetings in Scotland with the Crown Office and Procurator Fiscal Service, lawyers and NHS. This comparative perspective was integrated into our recommendations.

Three further seminars were held to disseminate the recommendations and receive further feedback. Attendees included all project partners, along with other interest groups in the area of medical error. Insights and suggestions received during the seminars were fed into our recommendations. For example, a timeframe for completing investigations was amended in line with suggestions made by police and CPS representatives.

The recommendations are being widely disseminated through our partners and a project website (linked to the School of Law site) aimed at those affected by criminal investigations into medical error, as well as medical and legal professionals. They were also the subject of a public lecture by Professor Brazier in April 2013. Working closely with the University of Manchester press office, we issued a press release. This led to coverage by – among others – Radio 4’s Today Programme and BBC News.

We have planned meetings with policy-makers and MPs. Some have worked with us throughout the project, and others contacted us in response to our media appearances. Many are pursuing campaigns aligned with our recommendations. Our aim is for our proposals to be included in future policy. The project team are also seeking to change legislation in the wake of the Mid Staffordshire NHS Foundation Trust Inquiry. The successful collaborations developed within the two projects are ongoing, with all parties keen to engage with our academic research in future.