General Medical Council

Factsheet: Dr Bawa-Garba's case

The criminal case

Did the criminal court take into account system failures?

Yes they did. Systemic issues at the hospital where Dr Bawa-Garba was working were taken into account by the Crown Court and were also subsequently considered by the Court of Appeal when Dr Bawa-Garba unsuccessfully sought permission to appeal her conviction.

Were Dr Bawa-Garba's reflections used in the criminal trial?

No. The Medical Protection Society (MPS), which represented Dr Bawa-Garba at her criminal trial, has made it clear that the doctor's reflective notes were not part of the evidence before the court and jury. Dr Pallavi Bradshaw, from the MPS, explains this in her blog for GP Online. The court also highlighted that no weight should be given to **any** remarks documented after the event. The QC who prosecuted the case for the Crown Prosecution Service also confirmed that the doctor's reflective notes did not form part of the case.

What is the legal status of reflective documents?

While we don't ask for reflective notes from doctors in order to investigate a concern, ultimately all written materials, including reflections, are potentially disclosable in the context of litigation: currently there is no legal privilege shielding them from disclosure.

The MPTS hearing

What should the Medical Practitioners Tribunal have taken into account when they considered the case?

The High Court found that the Tribunal had failed to respect the findings of the jury in convicting Dr Bawa-Garba of gross negligence manslaughter in the Crown Court. The Tribunal revisited the extent of the doctor's personal culpability and reached a different conclusion from the criminal court findings, which a Tribunal does not have the powers to do. The High Court also found that the Tribunal, in deciding Dr Bawa-Garba's sanction,

had not taken sufficient account of the GMC's statutory duty to consider public confidence in the profession.

The GMC appeal

Why did the GMC appeal?

We had to appeal because, in reaching their decision, the independent Tribunal wrongly revisited the findings of the criminal court and the basis upon which the jury convicted Dr Bawa-Garba. In doing so it reached its own less severe view of the degree of Dr Bawa-Garba's personal culpability when considering sanction.

By doing this the Tribunal failed to comply with the law, and was wrong to have proceeded as it did. The judgement handed down by the High Court said: "The Tribunal did not give the weight required to the verdict of the jury, and it was simply wrong to conclude that, in all the circumstances, public confidence in the profession and its professional standards could be maintained by any sanction short of erasure."

We therefore had to appeal to ensure that the case was dealt with lawfully and in accordance with both our and the Tribunal's statutory obligations.

Dr Bawa-Garba's appeal

What does this latest development in the case mean?

Dr Bawa-Garba's is appealing the Divisional Court's judgment (25 January 2018) that she should be removed from the register. The appeal will now be listed for a full hearing by three Court of Appeal judges later this year. The appeal is likely to be heard before the end of July 2018.

What will the GMC's role in the appeal be?

Dr Bawa-Garba is appealing the Divisional Court's judgment (25 January 2018) that she should be removed from the register.

As the permission to appeal has now been granted, the decision of the Divisional Court will no longer itself provide an authoritative statement of the legal positon.

It is important that the issues raised in this case are now fully considered by the Court of Appeal so they can they provide authoritative guidance, not just in the present case but for future cases involving criminal convictions. This appeal will provide helpful clarity for the profession in the future on a number of issues, including:

- Whether the GMC and the Divisional Court are correct in their understanding that it is unlawful for an MPT to revisit the findings of a criminal court.

- Whether the fact that a doctor has been convicted by a criminal court of causing the death of a patient through their own gross negligence requires particularly serious action to be taken in order to maintain public confidence in the profession and in its professional standards.

- Whether a finding that a doctor's fitness to practise is impaired by reason of a conviction for gross negligence manslaughter is fundamentally incompatible with being a doctor.

We will therefore play our full part in making submissions to the Court of Appeal so the judges can reach a conclusion on the important issues raised in the appeal.

We have been listening to the concerns expressed by the profession about criminalising doctors. That is why we have commissioned a cross-UK, independent review into how gross negligence manslaughter and culpable homicide in Scotland are applied to medical practice. The review, led by Dame Clare Marx, will examine what needs to be done to improve how existing law, procedures and processes are applied, whilst still protecting the public and maintaining confidence in the medical profession. The review will also look at how the GMC should handle cases involving gross negligence manslaughter and culpable homicide.

Reflective practice and the reflective practitioner

Does the GMC use reflective notes when investigating a concern about a doctor?

We don't ask for reflective notes from doctors in order to investigate a concern.

When we met with the Royal College of Paediatrics and Child Health recently, they raised questions about the wording of one of our standard investigation letters which was intended to seek evidence of support for the doctor and/ or concerns. Although the letter does not ask colleges to provide reflective statements, we agreed this is not as clear as it should be.

We are reviewing all of our documentation to make sure that they are absolutely clear that we are not seeking reflective notes from third parties.

Can a Royal College provide such information without a doctor's consent?

Colleges should ask for explicit consent from the doctor before disclosing any personal information. There are very limited circumstances where a college might disclose without consent, such as if they are required to by law or it can be justified in the public interest. Even in these circumstances the doctor should be advised of any disclosure.

Should doctors just be writing a bare minimum in their reflective writing from now on?

The focus of reflection should be on learning, rather than what has gone wrong or writing in length about what has happened. We are working with other organisations to provide clear guidance for all doctors on how to approach reflective practice. We have also begun conversations with other regulators on how we can better support team based reflection, and the scope for joint guidance.

As far as possible, patient details in any reflections and feedback should be entered anonymously, so individuals can't be identified from what is written (page 7 of the Academy of Medical Royal College's guidance on Improving feedback and reflection to improve learning).

Your professional duty of candour says: 'you must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress.' In these situations, there shouldn't be anything recorded in reflective notes that the patient, or those close to the patient, is not already aware of. If a doctor faces a complaint, and they choose to share their reflections, being able to provide evidence of their openness and insight will help them demonstrate to us that they are fit to practise.

Other issues relating to this case

What about other doctors who were responsible for care at the hospital?

The consultant is no longer on the UK medical register which means he cannot practise as a doctor in the UK. We removed him from the register and withdrew his licence to practise in 2012 for administrative reasons. Under our legislation, we can only investigate doctors who are registered with us.

What action are you taking to address wider issues raised by the case?

We are taking a range of actions, including:

- **Reflective practice:** We are working with key organisations across the UK including the Academy of Medical Royal Colleges, the Conference of Postgraduate Medical Deans, the BMA, the BMA's Junior Doctors Committee, and the Medical Schools Council - to provide clear guidance for all doctors and medical students on how to approach reflective practice.

- **Medical manslaughter:** Dame Clare Marx will lead our review to explore how gross negligence manslaughter* is applied to medical practice, in situations where the risk of death is a constant and in the context of systemic pressure. The review will bring together health professional leaders, defence bodies, patient, legal and

criminal justice experts from across the UK, and will aim to report by the end of the year.

- **Raising concerns:** We will push for the standardisation of exception reporting across England and mechanisms for raising concerns in the devolved nations. We will work with the BMA, systems regulators and the wider medical profession to improve how doctors of all grades, across the UK, can register safety concerns about working in an under-resourced environment.

- **Work stress, mental health and wellbeing:** We are developing a programme of work to tackle the causes and impact of work on the mental health and wellbeing of doctors.

Haven't the GMC's actions had the effect of punishing the doctor?

Our approach is absolutely not to be punitive when doctors make mistakes but to protect patients and the public's confidence in the profession.

Charges of gross negligence manslaughter* against medical practitioners are extremely rare. As was made clear by the judge in this case, gross negligence manslaughter is not about mere mistakes such as a missed diagnosis, a series of mistakes or even several missed opportunities. In this case, as the Court made clear in its judgment 'Dr Bawa-Garba's failures that day were not simply honest errors or mere negligence, but were truly exceptionally bad'. The judge also made clear that wider systems issues and pressures had been taken into account in the original criminal conviction and in the appeal where that conviction was upheld.

Couldn't anyone who makes a mistake be in the GMC's sights?

No. In recent years we have significantly refocused our fitness to practise processes so that we only fully investigate those complaints involving serious or persistent concerns. In the past four years alone we have reduced the number of investigations of single clinical incidents by 56 per cent.

We have invested heavily in our teams on the frontline, in each of the four countries, to support doctors in their day-to-day professional practice, to try and avert the risk of harm before it happens.

The number of full investigations is also falling, from 2,265 in 2011 to 1,436 in 2016. The number of sanctions and warnings fell by eight per cent in the same period. We've seen a 12 per cent fall in doctors receiving conditions or undertakings and a drop of almost a third in doctors receiving warnings.

Even in the majority of cases where relatively serious clinical failures occur (not honest errors or mere negligence) it is unlikely to result in serious action being taken against a

doctor's registration: our primary focus is on the likelihood of repetition and the doctor's ability to provide good care going forward.

Should doctors be exempt from gross negligence manslaughter* charges?

The GMC has no part in determining criminal law or sentencing. As the law stands, doctors are not exempt from gross negligence manslaughter* charges.

It is clear that there is a need to examine the wider issues around gross negligence manslaughter*, including the expertise and consistency applied in the initiation and investigation of cases. That is why we have committed to a programme of work, bringing together health professional leaders, defence bodies, patients, and legal and criminal justice experts from across the UK to explore how gross negligence manslaughter* is applied to medical practice, in situations where the risk of death is a constant and in the context of systemic pressure.

We have also made a submission to the UK Government's review of medical manslaughter in England. Giving evidence, our Chair, Professor Sir Terence Stephenson, said that doctors' reflections are so fundamental to their professionalism that the UK and devolved governments should consider providing legal protection.

Is the GMC being consistent towards cases where a doctor has been convicted of gross negligence manslaughter?

The GMC's position on convictions for the serious offence of gross negligence manslaughter has been consistent. Of the eight cases we have dealt with since 2004 following gross negligence manslaughter convictions, all but one resulted in removal from the register. In all cases we put forward that the doctor's name should be removed from the register.

In the one case where the doctor was not removed from the register our sanction submission had been for erasure but the panel decided on a 12 month suspension instead. We had concerns about this decision but at the time we did not have the right of appeal.

Isn't this case going to prevent doctors from being open and honest when things have gone wrong?

We are sorry that this case has had such a significant impact on the profession, and that as a result, many doctors are feeling upset and unsure about their practice and their working environments. That was never our intention and we know that we have a huge amount to do to rebuild trust. It's vital that doctors are supported to be open and honest about mistakes, and we are committed to supporting and promoting this culture across the UK's health services. Doctors who are candid and show insight into their mistakes are not just benefiting the wider health system but themselves too. As the Medical Protection Society (MPS) explains, if a doctor faces a complaint, being able to provide evidence of their openness and insight will help them demonstrate to us that they are fit to practise.

A doctor being charged with gross negligence manslaughter* is still incredibly rare, and convictions are rarer still. In this case the Crown Prosecution Service reopened the case following the evidence given by a clinical expert at Jack Adcock's inquest. The MPS, which represented Dr Bawa-Garba at her criminal trial, has made clear that the doctor's reflective notes were not part of the evidence before the Crown Court and jury. The court also highlighted that no weight should be given to any remarks documented after the event. The QC who prosecuted the case for the Crown Prosecution Service has also confirmed that the doctor's reflective notes did not form part of the case.

BAPIO has raised concerns that the GMC has shown bias against BME doctors. Is this true?

We take our responsibility to be a fair and transparent regulator very seriously.

As BAPIO is aware, we conduct detailed research on an ongoing basis to improve our understanding of what drives overrepresentation of different groups in our fitness to practice procedures, and whether cases are treated fairly. The consistency of our fitness to practise decision-making is also audited independently to ensure it is in line with our published guidance, and is not discriminatory. These audits have always found our decisions to be consistent with this guidance, and that the guidance itself does not introduce bias.

We make every effort to be as transparent as possible about our fitness to practise data and our analyses to improve our understanding of what drives particular trends. We publish information about this every year in our *The state of medical education and practice report*. Looking across all of our analyses and research we see no evidence of bias in GMC decision-making related to ethnicity.

We have identified a wide range of factors that influence the proportion of complaints about doctors that are formally investigated and from there, result in sanctions or warnings. These include the source of complaint, type of work done by the doctor, and the types of allegations made about them. We continue to investigate these and other factors as part of our ongoing research and will continue to publish our analyses as they are completed.

This continued scrutiny is supported by the Black and Minority Ethnic Doctors Forum, which is hosted by the GMC. Further information about our work in this area can be found in our response to BAPIO's open letter.

What is the GMC doing to influence key organisations to address the pressure on the system?

We work closely with employers, national education and training bodies, the profession and other regulators to identify and address pressures in the system, particularly where there are risks to patients and doctors. We sit on national information sharing groups and

risk summits in all countries of the UK. In England, we sit on the Joint Strategic Oversight Group in England alongside system leaders from the Care Quality Commission, NHS improvement, NHS England and Health Education England, to voice our concerns and influence change. We also use the data we hold to determine whether organisations which employ doctors in training continue to meet the standards we set for those environments, or whether we need to intervene to protect doctors and patients.

In addition, we raise our concerns publically. In 2016, we sent a clear message to government, employers and regulators, that there was a state of unease within the medical profession and that the system could not continue in this way. In 2017, we urged organisations involved in training and recruitment to act now, to avert greater pressure over the coming years.

We will continue to speak up about issues that affect doctors' abilities to meet our standards – through all means necessary.

What can the GMC do if a doctor's training environment is unsafe?

Organisations managing and delivering undergraduate and post-graduate medical education and training must follow our standards – *Promoting excellence: standards for medical education and training.*

Usually concerns will be resolved locally, but where this doesn't happen satisfactorily, these may be escalated to the local/national post-graduate dean's office. Serious or prolonged concerns will be escalated to us.

We continually monitor the safety of training environments, including our programme of visits and the evidence from our *national training survey*. We will not hesitate to take action if the safety of trainees and/or patients is at serious risk. In the most serious cases we will consider whether it is appropriate to remove trainees from particular locations. For example, we required doctors in training to be removed from a department at East Kent Hospitals University NHS Foundation Trust in March 2017, in response to poor levels of clinical supervision.

What is the GMC's advice on raising concerns?

Escalate, document, but don't walk away.

Where rota gaps and patient demand are affecting you and risking patient safety, it is vital you escalate your concerns and document them; but don't walk away. You should work with colleagues to provide the safest care that you can with the resources available to you.

As a regulator we can't fill rota gaps or decrease patient demand, but we can use the information and data that you report as evidence to act – where our legislation allows – and to call on all those responsible to address the issues you've raised.

If you're in a leadership role and concerns are reported to you, you have a responsibility to act by:

- putting the matter right - if that is possible
- investigating and dealing with the concern locally
- referring serious or repeated incidents, or complaints, to senior management or the relevant regulatory authority.

We know that many of you have commented that the flowchart from our *Raising and acting on concerns about patient safety* guidance looks complicated. That's because we know you work in a complex system. It's not there to place sole responsibility on you but to show you who you can call on for support.

If you don't know who to report concerns to, you should ask your employer as soon as possible. If you work in an NHS trust in England, find out who your Guardian of Safe Working is because they can help you too. And your Freedom to Speak Up Guardian will also be able to offer support in raising a concern.

The case highlights the importance of supporting doctors when they return from long periods of leave, such as maternity leave. What is the GMC doing to help this?

Doctors in leadership or management positions should make sure that doctors have a relevant induction and have access to an appropriate mentoring arrangement, where relevant. Our guidance on 'Leadership and Management for all doctors', paragraphs 55 – 59, sets that out clearly.

Those responsible for managing and delivering undergraduate and postgraduate medical education and training must make sure that doctors in training have appropriate support on returning to a programme following a career break (requirement 3.11 outlined in '*Promoting excellence: standards for medical education and training*'). We check on this through the national training survey, where we ask doctors in training the following: *'How supportive is the environment for those returning to work following a career break?'*. We also check on this when we visit medical schools, deaneries and local Health Education England (HEE) offices, and education providers across the UK.

The BMA and HEE are leading on improvements in this area, through the 'Supported Return to Work Project', which has provided £10 million a year in new investment to improve the return to work process. The BMA also have helpful information on their website about returning to practice after prolonged absences and a BMJ learning module on returning to work.

Was the GMC's decision influenced by the media?

Absolutely not. In any case where the Medical Practitioners Tribunal makes a decision which imposes a lesser sanction than we sought at the hearing, we review the decision and consider whether the sanction (if any) imposed by the Tribunal is sufficient to protect the public (including public confidence in the medical profession). The criteria which we apply are published on our website at Appeals by the GMC pursuant to s.40A of the Medical Act 1983 ("s.40A appeals") – Guidance for Decision-makers.

That is what we did here. The Tribunal made an error in law and this was why we appealed. We do not base our decisions on newspaper reports, social media discussion or a doctor's background.

Useful links

Since 25 January, we've answered many questions and correspondence about this case. Here we've brought these together in one place:

- Dr Colin Melville, our Director of Education and Standards, responds to some of your initial questions
- Our blog post addresses your frequently asked questions about the outcome of our High Court appeal
- Charlie Massey, our Chief Executive, writes in *The BMJ* about why we decided to appeal to the High Court
- The Medical Protection Society (MPS), who defended Dr Bawa-Garba in the criminal proceedings and MPTS hearing, corrects misinformation about the use of her e-portfolio
- Charlie Massey responds to BAPIO's open letter to us about this case on our blog
- Charlie Massey responds to a letter from Dr Sarah Wollaston MP, Chair of the Health Select Committee
- Professor Sir Terence Stephenson responds to Nick Ross's letter about the case in the BMJ

Court judgements

Visit the links below if you want to know more about the Court of Appeal and High Court's judgements in this case to date.

- Sir Brian Leveson's judgement on the criminal proceedings in the Court of Appeal, 8 December 2017

- Mr Justice Ouseley and Lord Justice Gross' judgement on the GMC's appeal in the High Court, 25 January 2018

* manslaughter by gross negligence and culpable homicide in Scotland