IN THE MATTER OF:

AN APPEAL UNDER SECTION 40A OF THE MEDICAL ACT 1983

AND

DR HADIZA BAWA-GARBA

NOTE OF ADVICE

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1. I am asked to advise on whether the test for appealing the case of Dr Bawa-Garba to the High Court is met and, if so, what are the prospects of success of such an appeal.

Relevant background

2. The Medical Practitioners Tribunal ("MPT") hearing in Dr Bawa-Garba's case began on 20 February and concluded on 12-13 June 2017. The allegation against Dr Bawa-Garba was admitted and was that:

   (1) on 4 November 2015 at Nottingham Crown Court, you were convicted of manslaughter on the grounds of gross negligence; and

   (2) on 14 December 2015, you were sentenced to 24 months' imprisonment suspended for 24 months.

3. The most authoritative account of the background to the MPT hearing appears in the summary of the facts provided by Sir Brian Leveson P in Dr Bawa-Garba's unsuccessful appeal against her conviction (Hadiza Bawa-Garba v R [2016] EWCA Crim 1841):

   > 3. *Dr Bawa-Garba is a junior doctor specialising in paediatrics. In February 2011, she had recently returned to practice as a Registrar at the Leicester Royal Infirmary Hospital after 14 months of maternity leave. She was employed in the Children's Assessment Unit of the hospital ("the Unit") which was an admissions unit comprising of 15 places (beds and chairs) which would receive patients from Accident and Emergency or from direct referrals by a GP. Its purpose was to assess, diagnose and (if appropriate) then treat children, or to admit them onto a ward or to the Paediatric Intensive Care Unit as necessary.*

4. *The case concerns the care and treatment received by Jack Adcock, a six year old boy (born on 15 July 2004) who was diagnosed from birth with Downs Syndrome (Trisomy 21). As a baby, he was treated for a bowel abnormality and a "hole in the heart" which required surgery as a result of which he required long-term medication called enalapril and he was more susceptible to coughs, colds and resulting breathlessness. In the past Jack had required antibiotics for throat and chest infections, including one hospital admission for pneumonia. However, he was well supported by a close family, local doctors and learning support assistants and he was a thriving little boy, who attended a mainstream pre-school nursery and then a local primary school. He enjoyed playing with his younger sister and was a popular and energetic child.*

5. *On Friday 18 February 2011, Jack's mother, Nicola Adcock, together with his grandmother, took Jack to see his GP, Dr Dhillon. Jack had been very unwell throughout the night and had not been himself the day before at school. The GP was also very concerned and he decided that Jack should be admitted to hospital immediately. Jack presented with dehydration caused by vomiting and diarrhoea and his breathing was shallow and his lips were slightly blue.*

6. *When Jack arrived and was admitted to the Unit at about 10.15 am, he was unresponsive and limp. He was seen by Sister Taylor, who immediately asked that he be assessed by the applicant, then the most senior junior doctor on duty. For the following 8-9 hours, he was in the Unit, under the care of three members of staff; at about 7.00 pm, he was transferred to a ward. During his time at the Unit, he was initially treated for acute gastro-enteritis (a stomach bug) and dehydration. After an x-ray he was subsequently treated for a chest infection (pneumonia) with antibiotics. The responsible staff were Dr Bawa-Garba and her two co-accused [Nurse Isabel Amaro and Ward Sister Theresa Taylor].*

7. *In fact, when Jack was admitted to hospital, he was suffering from pneumonia (a Group A Streptococcal infection, also referred to as a "GAS" infection) which caused his body to go into septic shock. The sepsis resulted in organ failure and, at 7.45 pm, caused his heart to fail. Despite efforts to resuscitate him (which were initially hampered by the mistaken belief that Jack was a child in the "do not resuscitate" or DNR category), at 9.20 pm, Jack died.*

4. The prosecution in the criminal case relied on a substantial number of failings by Dr Bawa-Garba which were said to have contributed to the death of Jack Adcock. They included:

- Dr Bawa-Garba's initial and hasty assessment of Jack (at about 10.45-11am) after receiving the results of blood tests which ignored obvious clinical findings and symptoms; and

- her subsequent consultations and the reassessment of Jack's condition, in particular, that she:

- did not properly review a chest x-ray taken at 12.01 pm which would have confirmed pneumonia much earlier;
- at 12.12 pm, did not obtain enough blood from Jack to properly repeat the blood gas test and that the results she did obtain were, in any event, clearly abnormal but she then failed to act upon them;
- failed to make proper clinical notes recording times of treatments and assessments;
- failed to ensure that Jack was given appropriate antibiotics timeously (more particularly, until four hours after the x-ray); and
- failed to obtain the results from the blood tests she ordered on her initial examination until about 4.15 pm and then failed properly to act on the obvious clinical findings and markedly increased test results. These results indicated both infection and organ failure from septic shock (CRP measurement of proteins in the blood indicative of infection, along with creatinine and urea measurements both indicative of kidney failure).

5. In rejecting her appeal, the Court of Appeal referred (at [36]) to the "truly exceptional degree of negligence which must be established" if gross negligence manslaughter is to be made out. The Court referred to another recent case (R v Sellu [2016] EWCA Crim 1716, at [151]) in which the Court of Appeal identified directions which provide the sort of assistance juries require (and which reveal the type of conduct required to reach the threshold of gross negligence manslaughter):

> *something which was truly exceptionally bad which showed such an indifference to an obviously serious risk of death of the deceased and such a departure from the standard to be expected as to amount to a criminal act and omission and so to be the very serious crime of manslaughter.*
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> Or
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> *. . . when you are considering the conduct of Dr [X], you may find it helpful to concentrate on whether the prosecution have made you sure that the conduct of Dr [X], in all the circumstances you have heard about and as you find them to be, fell so far below the standard to be expected of a reasonably competent General Practitioner that, in your assessment, his breach of duty – his negligence – should be characterised as gross in the sense that it was truly exceptionally bad and was such a departure from that standard that it consequently amounted to it being criminal and thus the criminal offence of gross negligence manslaughter.*

6. One other relevant piece of background is that Nurse Amaro (who was also convicted) was subsequently struck off the Register by the Conduct and Competence Committee of the Nursing and Midwifery Council on 4 August 2016. This decision was reached despite the Committee accepting that Nurse Amaro had fully remediated, demonstrated substantial insight into her misconduct and had practised safely since the incident. The Committee concluded that: "public confidence in the nursing profession and in the NMC as its regulator would be undermined were the panel not to impose a striking-off order".

The MPT's decision

7. The MPT concluded that a finding of impairment was required to maintain public confidence and proper standards in the profession. However, the MPT went on to impose a 12-month suspension (with a review) as sanction. In rejecting erasure, the MPT had regard to the following mitigating factors (at [18]):

- *Other than this matter, you have an unblemished record as a doctor*
- *You were of good character prior to your offence*
- *You remained employed by the Trust up until your conviction in 2015*
- *There is no evidence of any concerns being raised regarding your clinical competency before or after your offence*
- *The length of time which has passed since your offence*
- *Before the events of 18 February 2011, you had recently returned from maternity leave and whilst you had completed some on-call shifts, this was your first shift in an acute setting*
- *On the day in question, you were covering the CAU, the emergency department and the ward*
- *The multiple systemic failures identified in the Trust investigation following the events of 18 February 2011*
- *There is no evidence to suggest that your actions on 18 February 2011 were deliberate or reckless.*

8. The MPT expanded on the failures at the hospital at [28]:

> *The Tribunal had regard to the oral evidence of Dr Cusack, who stated that following the events of 18 February 2011, a Trust investigation was carried out which highlighted multiple systemic failures which existed at the time of these events. These included failings on the part of the nurses and consultants, medical and nursing staff shortages, IT system failures which led to abnormal laboratory test results not being highlighted, the deficiencies in handover, accessibility of the data at the bedside, and the absence of a mechanism for an automatic consultant review. The Tribunal therefore determined that whilst your actions fell far short of the standards expected*

and were a causative factor in the early death of Patient A, they took place in the context of wider failings.

9. The MPT concluded at [32]:

> *. . . that public confidence in the profession would not be undermined by a lesser sanction; your actions were neither deliberate nor reckless. Although your actions resulted in the early death of Patient A, you do not present a continuing risk to patients. The Tribunal did not consider that your failings are irremediable; indeed it has already found that you have remedied them.*

Relevant law

10. Section 40A of the Medical Act 1983 ("1983 Act") provides (as relevant):

> *(1) This section applies to any of the following decisions by a Medical Practitioners Tribunal –*
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> *(a) a decision under section 35D giving –*
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> *(i) a direction for suspension, including a direction extending a period of suspension;*
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> *. . .*
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> *(2) A decision to which this section applies is referred to below as a "relevant decision".*
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> *(3) The General Council may appeal against a relevant decision to the relevant court if they consider that the decision is not sufficient (whether as to a finding or a penalty or both) for the protection of the public.*
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> *(4) Consideration of whether a decision is sufficient for the protection of the public involves consideration of whether it is sufficient –*
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> *(a) to protect the health, safety and well-being of the public;*
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> *(b) to maintain public confidence in the medical profession; and*
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> *(c) to maintain proper professional standards and conduct for members of that profession.*
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> *. . .*
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> *(6) On an appeal under this section, the court may –*
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> *(a) dismiss the appeal;*
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> *(b) allow the appeal and quash the relevant decision;*
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> *(c) substitute for the relevant decision any other decision which could have been made by the Tribunal; or*
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> *(d) remit the case to the MPTS for them to arrange for a Medical Practitioners Tribunal to dispose of the case in accordance with the directions of the court,*
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> *and may make such order as to costs . . . as it thinks fit.*

11. The correct approach of the Court on appeals under s. 40A has now been authoritatively established by the Divisional Court in General Medical Council v Jagjivan & Anor [2017] EWHC 1247 (Admin), at [39-40]:

> *As a preliminary matter, the GMC invites us to adopt the approach adopted to appeals under section 40 of the 1983 Act, to appeals under section 40A of the 1983 Act, and we consider it is right to do so. It follows that the well-settled principles developed in relation to section 40 appeals (in cases including: Meadow v General Medical Council [2006] EWCA Civ 1390; [2007] QB 462; Fatnani and Raschid v General Medical Council [2007] EWCA Civ 46; [2007] 1 WLR 1460; and Southall v General Medical Council [2010] EWCA Civ 407; [2010] 2 FLR 1550) as appropriately modified, can be applied to section 40A appeals.*
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> *In summary:*
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> > *i) Proceedings under section 40A of the 1983 Act are appeals and are governed by CPR Part 52. A court will allow an appeal under CPR Part 52.21(3) if it is 'wrong' or 'unjust because of a serious procedural or other irregularity in the proceedings in the lower court'.*
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> > *ii) It is not appropriate to add any qualification to the test in CPR Part 52 that decisions are 'clearly wrong': see Fatnani at paragraph 21 and Meadow at paragraphs 125 to 128.*
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> > *iii) The court will correct material errors of fact and of law: see Fatnani at paragraph 20. Any appeal court must however be extremely cautious about upsetting a conclusion of primary fact, particularly where the findings depend upon the assessment of the credibility of the witnesses, who the Tribunal, unlike the appellate court, has had the advantage of seeing and hearing (see Assicurazioni Generali SpA v Arab Insurance Group (Practice Note) [2002] EWCA Civ 1642; [2003] 1 WLR 577, at paragraphs 15 to 17, cited with approval in Datec Electronics Holdings Ltd v United Parcels Service Ltd [2007] UKHL 23, [2007] 1 WLR 1325 at paragraph 46, and Southall at paragraph 47).*
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> > *iv) When the question is what inferences are to be drawn from specific facts, an appellate court is under less of a disadvantage. The court may draw any inferences of fact which it considers are justified on the evidence: see CPR Part 52.11(4).*
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> > *v) In regulatory proceedings the appellate court will not have the professional expertise of the Tribunal of fact. As a consequence, the appellate court will approach Tribunal determinations about whether conduct is serious misconduct or impairs a person's fitness to practise, and what is necessary to maintain public confidence and proper standards in the profession and sanctions, with diffidence: see Fatnani at paragraph 16; and Khan v General Pharmaceutical Council [2016] UKSC 64; [2017] 1 WLR 169, at paragraph 36.*

vi) However there may be matters, such as dishonesty or sexual misconduct, where the court "is likely to feel that it can assess what is needed to protect the public or maintain the reputation of the profession more easily for itself and thus attach less weight to the expertise of the Tribunal …": see Council for the Regulation of Healthcare Professionals v GMC and Southall [2005] EWHC 579 (Admin); [2005] Lloyd's Rep. Med 365 at paragraph 11, and Khan at paragraph 36(c). As Lord Millett observed in Ghosh v GMC [2001] UKPC 29; [2001] 1 WLR 1915 and 1923G, the appellate court "will afford an appropriate measure of respect of the judgment in the committee … but the [appellate court] will not defer to the committee's judgment more than is warranted by the circumstances".

vii) Matters of mitigation are likely to be of considerably less significance in regulatory proceedings than to a court imposing retributive justice, because the overarching concern of the professional regulator is the protection of the public.

viii) A failure to provide adequate reasons may constitute a serious procedural irregularity which renders the Tribunal's decision unjust (see Southall at paragraphs 55 to 56).

Advice

12. There can be no question that the MPT's decision to suspend Dr Bawa-Garba's registration falls within s. 40A(1)(a) of the 1983 Act and is appealable.

13. As a decision on sanction and based on the MPT's assessment of what is required to maintain public confidence and proper standards in the profession, the Court will approach the determination with some "diffidence". However, this needs to be balanced in the present case against the following factors:

- one of the "strands of the learning" developed by the Privy Council and incorporated in the modern doctrine in Fatnani (the limited relevance of evidence of mitigation) does not encourage diffidence in an appeal brought by the GMC (as opposed to one brought by a doctor);

- the MPT was not required to apply its expertise about clinical matters since the substantive determination had already been made in the criminal court; and

- the MPT did not form its own impression of Dr Bawa-Garba's character and insight since she did not give live evidence before it.

14. As is clear from the above summary of the MPT's determination, it relied principally on two matters: the circumstances at the hospital which may have contributed towards Jack's death and the remediation and personal mitigation in Dr Bawa-Garba's case. I do not consider that the GMC can go as far as to say that this was an error of fact or law. However, it is strongly arguable that the MPT placed too much weight on both matters.

15. As regards the first (conditions at the hospital), live evidence was given before the MPT by Dr Jonathan Cusack who was recalled by the defence at the sanction stage (D4/11-36).

16. However, Dr Bawa-Garba relied heavily on these "systemic" failings at her trial before Nicol J. The failings of the computer system, the lack of a Senior House Officer, the shortage of permanent nursing staff, Nurse Amaro's failings and so on are all referred to by Leveson P in her unsuccessful appeal against conviction to the Court of Appeal (see [17-18] in Bawa-Garba, above). [Although not entirely clear form the judgment, these appear to be references to what was relied at trial, rather than her appeal which was based on a misdirection.] As such, these matters must have been considered by the jury which was nonetheless satisfied that Dr Bawa-Garbo's conduct crossed the very high threshold of gross negligence in relation to her personal culpability.

17. For the MPT to rely on these same factors in mitigating Dr Bawa-Garba's conduct appears to be an attempt to go behind the verdict and may undermine Rule 34(3) & (5) of the General Medical Council (Fitness to Practise) Rules Order of Council 2004 ("2004 Rules") which provide:

> *Production of a certificate purporting to be under the hand of a competent officer of a Court in the United Kingdom or overseas that a person has been convicted of a criminal offence or, in Scotland, an extract conviction, shall be conclusive evidence of the offence committed.*
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> . . .
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> *The only evidence which may be adduced by the practitioner in rebuttal of a conviction or determination certified in the manner specified in paragraph (3) or (4) is evidence for the purposes of proving that he is not the person referred to in the certificate or extract.*

18. As regards the second (remediation), these factors are relevant to the question of the risk Dr Bawa-Garbo may pose to patients in the future (and to impairment), but are of more limited relevance to the public interest. Similarly, matters of personal mitigation are less relevant in professional conduct settings in relation to the public interest. I am surprised that the MPT did not make reference to Bolton v Law Society [1993] EWCA Civ 32, at [16] and Fatnani when the case is so plainly one of the public interest. The NMC Committee had this very firmly in mind in its decision in relation to Nurse Amaro and appears to have done a better job in separating out the different considerations.

Conclusion

19. For the above reasons, I consider that the GMC has a good chance (above 50%) of convincing a court that the MPT's decision was wrong in the relevant sense.

19 June 2017

IVAN HARE QC
Blackstone Chambers