

Dr Bawa Garba's appeal – FAQ

On 13 August 2018 the Court of Appeal over-turned an earlier decision by the Divisional Court that Dr Hadiza Bawa-Garba should be removed from the medical register. Dr Bawa-Garba will now be restored to the medical register, and the order of suspension imposed by the Medical Practitioners Tribunal (MPT) in June 2017 will be re-instated; this includes an MPT review hearing before Dr Bawa-Garba can return to practice. We fully accept the Court of Appeal's judgment, and we will ask the Medical Practitioners Tribunal Service (MPTS) to list the review hearing as soon as possible.

The case

There are a number of stages in this case, including several appeals, and court judgments. What happened, when?

Jack Adcock was admitted to Leicester Royal Infirmary on 18 February 2011, and sadly died later that day from sepsis. A number of failings in his care were identified. Following a police investigation the Crown Prosecution Service initially decided not to charge Dr Bawa-Garba and two nurses who were responsible for Jack's care. However, following the inquest into Jack's death which heard evidence from an expert paediatrician, the case was re-examined and the three were charged with gross negligence manslaughter.

At the conclusion of their Crown Court hearing, the jury found Dr Bawa-Garba and one of the nurses guilty by a majority of 10-2. Dr Bawa-Garba was given a two-year suspended sentence. She appealed against the conviction but her appeal was dismissed by the Court in December 2016.

The GMC cannot open a hearing on a conviction until the criminal court process is complete. The Medical Practitioners Tribunal (MPT) heard Dr Bawa-Garba's fitness to practise case and in June 2017 found her fitness to practise impaired as a result of her conviction, determining that she should be suspended from practice for 12 months and a review hearing should be held before her 12 months suspension expired.

The GMC appealed those findings following external legal advice. On 25 January 2018 the Divisional Court upheld that appeal, substituting the original suspension with erasure from the medical register. Dr Bawa-Garba appealed the Divisional Court's judgment and the Court of Appeal has now ruled that the Divisional Court's decision in January 2018 was

incorrect, and determined that the original 12-month suspension should stand. We fully accept the Court of Appeal's decision.

Why did the GMC contest this case?

Investigations and hearings are hard for everyone involved. As an independent regulator we are frequently called upon to take difficult decisions. We cannot shy away from our statutory responsibilities, but we recognise the significant impact they can have on doctors, patients and their families.

This has been a tragic case involving the death of a child and we understand the strength of feeling that's been expressed by all concerned. Incidents like this, where a doctor has been convicted of gross negligence manslaughter, are extremely rare, but serious.

Our assessment, informed by external legal advice, was that in reaching their decision to suspend Dr Bawa-Garba, the MPT wrongly revisited the findings of the criminal court and the basis on which the jury reached its verdict. This led us to believe that the tribunal had not acted lawfully, so we felt we had to appeal their decision.

On 25 January 2018 the Divisional Court agreed with this position, concluding that the tribunal had erred in law when it reached its own less severe view of the doctor's personal culpability, when determining its sanction. The judgment handed down by the Court of Appeal on 13 August 2018, now overturns the Divisional Court's decision. We fully accept the Court of Appeal's decision.

Does this change the GMC's view about whether a conviction of gross negligence manslaughter is compatible with being a doctor?

What the Court of Appeal's judgment makes clear is that each case should be judged on its own circumstances. In cases involving serious criminal convictions like gross negligence manslaughter, erasure will be appropriate in some cases and not in others. The GMC will always carefully consider the facts of each case when determining what action is necessary to protect the public or public confidence in the profession.

Does the GMC agree that patient safety could be impacted by this case, because doctors may no longer admit their mistakes and reflect openly?

We are totally committed to doing everything we can to support a speak-up culture in our health services. Doctors should never hesitate to act openly and honestly if something has gone wrong. They should also feel confident to reflect and learn from their experiences to develop their competence and expertise.

We have called for reflective notes to be protected in law. We are disappointed that the UK government has missed an opportunity to do this, by accepting the recommendations in Professor Sir Norman Williams rapid policy review into gross negligence manslaughter in healthcare, in England. 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. We believe that reflection is so fundamental to a doctor's medical practice that we will continue to press for legal protection.

The Academy of Medical Royal Colleges, the Conference of Postgraduate Medical Deans, the Medical Schools Council, and the GMC are also in the process of developing new joint guidance, to help doctors as reflective practitioners. The guidance will be published in the coming weeks.

What was considered by the jury in Dr Bawa-Garba's original criminal trial? Who has access to the transcripts?

We were not party to the criminal proceedings but the Court of Appeal and High Court's judgments in this case are available online:

- [Sir Brian Leveson's judgment on the criminal proceedings in the Court of Appeal, 8 December 2017](#)
- [Mr Justice Ouseley and Lord Justice Gross' judgment on the GMC's appeal in the High Court, 25 January 2018](#)

We do know that systemic issues at the hospital where Dr Bawa-Garba was working were taken into account by the Crown Court and that they were also subsequently considered by the Court of Appeal when Dr Bawa-Garba unsuccessfully sought to appeal her criminal conviction. Among the system pressures heard in court were:

- Medical and nursing staff shortages
- Failings by nurses and consultants
- IT system failures which led to abnormal laboratory test results not being highlighted
- Deficiencies in handover
- Issues with accessibility of data at the bedside
- Absence of a mechanism for an automatic consultant review

How is the GMC going to rebuild relationships with doctors across the UK?

This case has highlighted a range of issues, many of which the profession have been worried about for a long time, and which haven't been adequately understood or addressed by many working across our health systems. There is also no doubt that doctors' feel less supported and more vulnerable working in environments and systems under intense pressure. Over recent months we have been actively working with and listening to what doctors and medical leaders, across the UK, have been saying about our

role in this particular case; and we are in no doubt about the strength of feeling that's been expressed.

We are also clear that the process of learning and reflection do not just apply to the medical profession; we too have been reflecting on what we can do to address and rebuild trust and confidence.

We have publicly committed to delivering a comprehensive and targeted programme of work to tackle the specific issues that have been raised with us, including:

- Commissioning an independent review led by Leslie Hamilton, into how gross negligence manslaughter and culpable homicide are applied to medical practice
- Commissioning a major independent research programme led by Roger Kline and Dr Doyin Atewologun to help us understand why some doctors are referred to us by employers for fitness to practise issues more than others.
- Starting a UK-wide review of the factors that affect medical students and doctors' wellbeing, led by Professor Michael West and Dame Denise Coia, to agree priority areas for collaborative action that can help tackle the underlying causes of poor wellbeing.
- Exploring how we can incorporate human factors training into the training of our fitness to practise Case Examiners, and the medical experts used in our processes
- Continuing to collaborate with the British Medical Association, the wider profession, four UK governments and national partners to improve the consistency of how all doctors can register safety concerns about working in under-resourced environments.

However, we know that actions speak louder than words, and we will rightly be judged on the things we now do.

Other issues related to this case

Doesn't this case prove that any doctor could be targeted for a single clinical mistake?

This was not a case centred on simple mistakes. It concerned the tragic death of a young boy and the subsequent criminal conviction for gross negligence manslaughter, which in law requires a very high threshold to be met. It is an extremely rare thing for a doctor to be convicted of gross negligence manslaughter or culpable homicide. Since 2004 we have heard just nine such cases following criminal convictions.

In recent years we have also significantly refocused our fitness to practise processes and pushed our outdated legislation to the limit so that we only fully investigate those

complaints involving serious or persistent concerns. For example, by using early enquiries, we have reduced the number of investigations of single clinical incidents in those cases by 64% per cent. The number of full investigations is also falling, from 2,265 in 2011 to 1,436 in 2016. And the number of sanctions and warnings fell by eight per cent in the same period. We've also 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.

However, in a small number of cases there are exceptional circumstances, where even after we have considered the doctor's insight and remediation, we must also take account of our statutory responsibilities to maintain public confidence in the profession. This is particularly important following a serious criminal conviction.

Are the GMC's fitness to practise processes fair and unbiased?

We take our responsibility to be a fair and transparent regulator very seriously. As the host of the Black and Minority Ethnic (BME) doctors' forum we have been working constructively with members for a number of years. We do our utmost to ensure that all our processes are even-handed and just, listening and acting on feedback to make improvements to our processes. Independent reviews have consistently found that our fitness to practice processes and guidance are fair and consistent and do not introduce bias.

But we do know that there is an overrepresentation of BME doctors that have been referred to us by employers, and we want to know more about what is driving this, as well as whether there is an under representation of other doctors. That is why we are intensifying our efforts to better understand this issue through more detailed research, analysis and advice. We have commissioned Roger Kline and Dr Doyin Atewologun to lead this research, but we're not just committing to publishing a report. Their findings will allow us to work more closely with clinical leaders to properly develop supportive and open workplaces, where doctors' interactions with us, and with processes that we own, are appropriate and fair.

We hope this work will also give practical recommendations that we and others can act on to help change current referral trends. For our part, we're clear that if the research makes any findings about our current processes or outcomes, we will take action.

Does the GMC consider a conviction of any sort should result in erasure?

No. We do not seek erasure in all cases where doctors have a criminal conviction. But in cases where there are serious criminal convictions, notwithstanding remediation and insight on the part of the doctor, we must consider public confidence in the profession. Trust is at the heart of the patient-doctor relationship. We all need to have confidence in

the doctors who treat us and our families. A failure to act where a doctor is found guilty of a serious criminal conviction could seriously damage that trust.

We have been clear that we believe certain serious criminal convictions – such as murder, rape and paedophilia – should always require erasure. Gross negligence manslaughter is not one of those offences.

What does the GMC consider when making decisions about a doctors' fitness to practice?

The investigations we carry out depend on the nature of the concerns that have been raised with us. The information we gather may include the following:

- Further documentary evidence from employers, the complainant or other parties
- Witness statements
- Expert reports provided by senior clinicians on clinical matters
- An assessment of the doctor's performance by a team comprised of senior medics and lay members
- An assessment of the doctor's health by senior doctors
- An assessment of the doctor's knowledge of the English language.

We have well established and quality assured arrangements in place for securing expert clinical input. This has helped us to close at an early stage of our fitness to practise investigations a significant number of cases. However, there may be learning that we can bring to the way that the wider system uses expert medical evidence.

In addition, we are now looking at how we can build human factors training into the training of our case examiners and our pool of medical experts, and embed it in our interactions with Responsible Officers.

If a doctor arrives to a shift that's understaffed and affected by significant system pressures, what should they do? What action will be taken if an error occurs and are doctors protected if they take the correct actions?

If a doctor thinks their working conditions are unsafe, they should document the issue and escalate it at the earliest opportunity, but they shouldn't walk away. If doctors follow our guidance on raising concerns and the duty of candour, it will provide a level of protection to those who subsequently face a complaint to the GMC.

We are working proactively with the BMA, the wider profession, the four UK governments, and national partners to improve consistency in the ways doctors can register their safety concerns about working in under-resourced environments. Together with NHSI

Improvement, the Academy of Medical Royal Colleges, the British Medical Association, the Care Quality Commission, Health Education England, and NHS Employer, we have agreed a joint approach to improving exception reporting. And - in conjunction with the Care Quality Commission, the General Pharmaceutical Council, the Health and Care Professions Council, Health Education England, the Local Government and Social Care Ombudsman, the Nursing and Midwifery Council, and the Parliamentary and Health Service Ombudsman - we have launched a new protocol to provide a clear mechanism for organisations to raise concerns and arrange meetings where they can be discussed. The protocol is designed to ensure information is consistently shared in a timely, effective and co-ordinated way.

Date of publication: Monday 13 August 2018