Williams Review into Gross Negligence Manslaughter in healthcare – GMC written submission

Introduction

The case that has given rise to this review has been a tragedy for all concerned; a little boy lost his life, a family lost a loving son, a doctor lost her career, and the wider medical profession now feels less supported and more vulnerable in its efforts to care for patients and the public in a system under intense pressure.

The outcome of the case has served to highlight issues that have been present for a long time, but that are either insufficiently understood or inadequately addressed. They include (but are not limited to):

- The enormous challenges facing doctors at all levels working in system under pressure, and where accountability lies when things go wrong.
- The involvement of the criminal justice system where fatalities occur in a medical setting and whether the procedures and processes surrounding the investigation and prosecution of alleged gross negligence manslaughter (GNM) are sufficient to support fair and consistent decision making.
- The use of expert witnesses within criminal and regulatory proceedings
- The role of reflection in good medical practice and how this should be used to support learning and safe practice.
- How public confidence in the profession is maintained.
- The role of professional regulation in relation to these issues.
- The extent to which the case of Dr Bawa-Garba has served to act as lightning-rod for many of the underlying systemic pressures facing the health service and the medical profession.

It is to help us better understand and address these issues that we have invited Dame Clare Marx to lead an independent, UK wide review of GNM and culpable homicide and consider what might be done to improve the application of the existing law in cases involving doctors. The learning from the review will support just decision making and the application of the law, procedures and processes where allegations of GNM have arisen so that accountability is appropriately apportioned between healthcare systems and individual doctors. The terms of reference for Dame Clare's review are appended to this submission. We hope that the outputs of the Williams Review will help to inform Dame Clare's work when she reports her conclusions at the start of 2019.

Facts, reflections and actions

It will be important not to rush to solutions before the two reviews have run their course. Practical progress has already been hampered by widespread misunderstanding and misreporting of the facts.

Our oral evidence to the Review will enable the panel to explore specific questions that it has signalled will be of interest, including the role of reflective learning, consideration of mitigating and contextual factors within the GMC's fitness to practise proceedings, regulators' right of appeal and the use of expert opinions. The following paragraphs offer some additional points for preliminary consideration.

GMC proceedings: the facts

Much criticism has been levelled at the GMC over our action in appealing the decision of the Medical Practitioners Tribunal (MPT) not to erase Dr Bawa-Garba from the medical register following her conviction for GNM. However, 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 when deciding whether or not to issue an appeal 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.

We therefore never take the decision to appeal a Medical Practitioners Tribunal (MPT) finding lightly. An appeal will only be issued where, after careful consideration of all of the relevant circumstances, we conclude that the decision of the Tribunal was insufficient to protect the public, which includes a failure to take appropriate action to maintain public confidence in the medical profession. In each case we will also seek advice from external lawyers before proceeding.

The reason why we appealed the decision of the MPT in this case was the need to ensure that Dr Bawa Garba's case was dealt with lawfully and in accordance with both our and the MPT's statutory obligations, since:

- in reaching their decision, the MPT 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 MPT failed to comply with the law, and was wrong to have proceeded as it did.

In allowing our appeal, the Divisional Court confirmed that we were right to appeal the MPT's decision for those reasons, finding that:

- "the Tribunal did not respect the verdict of the jury as it should have. In fact, it reached its own and less severe view of the degree of Dr. Bawa-Garba's personal culpability. It did so as a result of considering the systemic failings or failings of others and personal mitigation which had already been considered by the jury; and then came to its own, albeit unstated, view that she was less culpable than the verdict of the jury established.

- The correct approach … is that the certificate of conviction is conclusive not just of the fact of conviction (disputed identity apart); it is the basis of the jury's conviction which must also be treated as conclusive. …

- the Tribunal had to approach systemic failings or the failings of others on the basis that, notwithstanding such failures, the failures which were Dr. Bawa-Garba's personal responsibility were "truly exceptionally bad", and those are summarised in the judgment of the (Court of Appeal Criminal Division). [See Annex 1]

- The Tribunal had to recognise the gravity of the nature of the failings, (not just their consequences), and that the jury convicted Dr Bawa-Garba, notwithstanding those systemic factors and the failings of others, and the personal mitigation it considered. The jury's verdict therefore had to be the basis upon which the Tribunal reached its decision on sanction."

- "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."

Dr Bawa Garba has now applied to the Court of Appeal for permission to appeal the Divisional Court's decision. Whilst it would not be appropriate for us to comment in detail on the application for permission to appeal, Dr Bawa Garba's Grounds of Appeal do not, as we understand them, demonstrate any arguable basis for concluding that the Divisional Court erred in its judgment.

A full timeline of the relevant legal proceedings is attached as Annex 2.

In view of the widespread misunderstanding about the facts of the case, links to the relevant legal judgements are shown on our website: https://www.gmc-uk.org/news/31576.asp . We have also sought to engage directly with the profession

and our partners to listen to their concerns and try to clarify the issues. Among the misunderstandings we have sought to correct are:

- It was not the case that Dr Bawa-Garba's reflective notes were used as evidence against her in either the court proceedings or the MPTS proceedings.
- Contrary to what has been claimed in social media and elsewhere, the systemic failings and failings of others were taken into account by the jury during the court proceedings which led to Dr Bawa-Garba's conviction.
- It is not correct that Dr Bawa-Garba did not have access to consultant advice.

We anticipate that the Clare Marx review will wish to look at the relationship between our fitness to practise sanctions guidance and our approach where doctors have been convicted of GNM. Although it is not our policy that doctors should always be erased in such cases, in the small number of cases that have arisen we have always sought erasure. Intent and practice must be properly aligned.

The criminal arena

Whatever the outcome of the court proceedings, the case has served to emphasise that much of the problem in relation to cases of alleged GNM involving doctors in fact lies at a much earlier stage, before cases ever get to the GMC. The issue is whether the cases that are investigated locally by a hospital, a coroner, the police and the CPS should be brought within the arena of criminal investigation in the first place or whether they are better addressed in other ways. Although definitive figures are hard to come by, the number of successful convictions compared to the number of criminal investigations and prosecutions is small. This may suggest that there are cases being pursued in the criminal arena that would be better dealt with in other ways. The chilling effect on doctors of this criminalisation of healthcare and the potentially adverse effect on future safe practice should not be underestimated.

We also understand that in Scotland, criminal prosecution is much more likely to be focused on the culpability of the organisation rather than that of individual healthcare practitioners. That is not to say that individual healthcare workers should not be accountable for their actions. But we need to understand the reasons for the different approaches and ensure that accountability is appropriately apportioned between systems and individuals and learn lessons from across the UK.

Expert witnesses

Another issue for the Clare Marx review will be the selection and use of medical experts within the criminal justice system. Is expertise that is appropriate and of a consistently reliable standard accessible to local investigators, the police, the coroner

service and the CPS to support just decision making at each stage of the investigatory process?

Within our own regulatory processes we have well established and quality assured arrangements in place for securing expert input. This has helped us to close at an early stage of our fitness to practise investigations a significant number of cases. There may be learning that we can bring to the way that the wider system uses expert medical evidence, including an understanding of human factors issues alongside clinical expertise. There may also be learning for us arising from the recent case, including the need to ensure that training in human factors is built into the training of our case examiners and our pool of medical experts.

Allegations of discrimination

Following the case of Dr Bawa-Garba there have been claims that we have acted in a discriminatory way and that our fitness to practise procedures exhibit institutional bias. This is not the case. We take our responsibility to be a fair and transparent regulator very seriously and independent analysis of our processes has shown that they are not disproportionate and that decisions are consistent and in line with our published processes. Research has indicated that it is the nature and seriousness of the allegations that is the primary driver of the outcome of a referral or investigation, rather than ethnicity.

There are, however, questions to be addressed about the over-representation of some groups in the cases that are referred to us from the NHS and elsewhere. We aim to work with employers to help us better understand and address the reasons for this, although solutions are unlikely to rest wholly with the GMC. Similar questions arise in relation to the cases likely to be investigated and prosecuted for GNM. Some research has indicated that BME groups are more likely to investigated and prosecuted. This is one of the issues that the Clare Marx review will wish to consider.

Reflection, learning and legal privilege

Reflection is central to learning and to safe practice and fundamental to medical professionalism. It is built into the requirements of Outcomes for graduates, the generic professional capabilities framework and supporting information for appraisal and revalidation. We have been working on guidance on reflective practice but have, in agreement with doctors' in training leaders, paused to enable us to do further work on this with them and our other partners. We hope to be able to publish co-produced guidance in summer 2018.

We have made it clear that the GMC will not ask for doctors' reflective records as part of the fitness to practise processes. But we do not control the actions of the

courts and recorded reflections, such as in ePortfolios or for CPD purposes, are not subject to legal privilege. Therefore disclosure of these documents might be requested by a court if it is considered that they are relevant to the matters to be determined in litigation. The likelihood of records needing to be produced in court may be reduced if reflective records focus on reactions to, and learning from, an incident.

For our part, we have concluded that because doctors' reflective records are so fundamental to their professionalism they should be treated as privileged and for parliament to legislate on this if it sees fit to do so.

Leadership, learning and raising concerns

Good leadership is crucial in creating a workplace environment where patients' interests are prioritised and staff are supported to maintain standards. If the top of the organisation can demonstrate that the good clinician is one who learns from experience this will help mitigate the fear of blame among staff which may act as a barrier to reporting errors.

But where concerns need to be raised, we provide guidance, workshops and a confidential helpline for doctors wishing to raise concerns. Indeed, we have recently re-affirmed the need to make sure doctors are supported to raise concerns (including the need for better national exception reporting data). Our annual National Training Survey will continue to provide valuable data on this issue, enabling us and our partners to act to make sure training environments are safe for doctors and patients. We will be engaging with employers and appropriate bodies on how data on concerns raised is collected and shared nationally to identify themes and learnings.

System pressures

The case of Dr Bawa-Garba has highlighted the challenges facing all doctors working in a health service that is under considerable pressure. We can and do act decisively with others to address problems where training is unsafe (for example, in East Kent and North Middlesex). But the pressures on the system are widespread and not isolated. It is therefore important to be clear that, whatever the outcome of the two reviews, the underlying systemic factors that have made this case such a lightning-rod for the medical profession, are likely to remain. Government and employers have a clear responsibility to ensure that the healthcare workforce is properly supported in its efforts to deliver safe and high quality care.

Professional regulation has a contribution to make in this area by working with employers, but it is not the solution. Moreover, part of the challenge for us in addressing these issues is the inadequacy of the legislative framework within which

we are required to take action. We have lobbied for many years for changes to that framework and although Governments have repeatedly promised us reform, they have consistently failed to deliver.

Supporting doctors

No one organisation can address all of the issues facing doctors, but in our new corporate strategy we have committed to playing our part.

In addition to our own work on reflective practice referred to above, we have begun conversations with other professional regulators about how, together, we can better support team-based reflection, and the scope for possible joint guidance.

Linked to learning and reflection is the need to ensure that doctors new to roles or retuning to practice are given appropriate induction and support. This is another theme that will be explored within Dame Clare's review. We already run a successful Welcome to UK Practice programme for doctors new to UK practice and our new corporate strategy commits us to significantly increasing the reach of this programme to include 80% of new registrants. Alongside this, in our discussions with employers we will bring renewed focus to how doctors can best be supported when they return to practice after a time away. For example, this could include providing dedicated support from our Regional Liaison Service if employers felt that would be helpful.

We have also commenced an important programme of work looking at the mental health and wellbeing of the entire medical workforce. The work is being led by Dame Denise Coia, Consultant Psychiatrist and Chair of Healthcare Improvement Scotland, and Professor Michael West, Professor of Work and Organisational Psychology at Lancaster University.

Public confidence

The need to 'promote and maintain public confidence in the medical profession' is one limb of our statutory objective, introduced in 2015 under the current Secretary of State. An equivalent requirement exists for the other healthcare professional regulators. It was the need to maintain public confidence in the profession that underlay our decision in relation to Dr Bawa-Garba. What the case has highlighted is the need for more work to ensure there is understanding of what that means in practice. The Dame Clare Marx review will be able to examine how regulation maintains 'public confidence'.

The complex trajectory of understanding

It is striking that the Significant Untoward Incident report has only just been released, some 7 years after the event and then only following a Freedom of Information request. This exemplifies the difficulty of reporting openly and factually these kinds of healthcare incidents and underlines the complicated web of overlapping organisational, individual and procedural factors and responsibilities that make it very difficult to publish information and explanation in a neutral way. This also makes it difficult to get to any resolution. In this case there has been trust, coroner, police, CPS, MDO, CQC, and GMC involvement - and now that Dr Bawa-Garba is appealing the case still remains open. Few people could be expected to understand the ambit of, and relationship between, these processes, and so rumour, professional anxiety and misinformation fill the void.

Amidst the twists and turns of the various processes, often confidential ones, run by multiple organisations over 7 years, effective, rapid and persuasive communications inevitably struggle to gain traction.

Communication and engagement

We anticipated that there was going to be a strong reaction to the outcome of the appeal. However the strength of feeling among the medical profession was far greater than expected and this has been confirmed by both those supporting Dr Bawa-Garba and by editors of medical trade publications. Much of the response has been stoked by misinformation about the criminal trial and this was particularly challenging to try and correct.

There is always a balance to be struck in terms of the tone of our communication and we sought to get our message across in a measured and non-inflammatory way.

We were proactive in reaching out to all stakeholder groups and the profession as a whole via trade press, social media and direct mail as well as undertaking national, regional and trade media interviews. We responded to direct feedback from front line staff and stakeholders and adapted our communications accordingly. We provided a range of public responses to letters from the Chair of the Health Select Committee and BAPIO as well as a number of open letters.

We continue to work with stakeholders to provide them with information that they can disseminate to their audiences – particularly around correcting misinformation.

Given the complexity of the issues and recognising that the GMC action has come at the end of a long and drawn out process the most effective way of engaging on these issues has been face to face. Since the outcome of the appeal we have met with thousands of doctors at all levels across the UK. These sessions have been led

by our field force teams. Although often challenging, this face to face contact has proven effective in ways that written communication has not. We will continue to seek out face to face opportunities to engage with the profession on the issues that this case has drawn out and will redouble our efforts to engage with the profession via social media and media channels.

At a strategic level we have engaged with senior leaders from across healthcare including doctor in training leaders, leaders of the BMA, BME Forum, and medical royal colleges. This has proven to be extremely useful in establishing the programme of work going forward and securing support to deliver that work.

Our offer

As part of our learning from this case we will undertake our own reflections process. But even before that begins, we are able to offer the following observations:

- We have commissioned a fundamental review of the application of the law concerning gross negligence manslaughter and culpable homicide to doctors which will be led by Dame Clare Marx.

- Within the Clare Marx review, there is a need to consider how regulation assures 'public confidence'.

- We have concluded that doctors' reflective notes should be privileged.

- We have undertaken to consider how we can incorporate human factors training into the training of our fitness to practise Case Examiners and medical experts used in our processes, and there is a need to consider how human factors training can be incorporated within the training of medical experts used in criminal and other processes.

Annex 1

Factual background to case, reflecting findings of criminal trial

The High Court confirmed in their judgment that the following paragraphs of the judgment of the Court of Appeal Criminal Division when they refused Dr Bawa Garba leave to appeal against her conviction on 29 November 2016 comprise the full and authoritative statement of the relevant facts and background to Dr Bawa Garba's conviction:

> "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.
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> 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 from 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 close family, local doctors and learning support assistants and he was a thriving little boy, who attended mainstream pre-school nursery and then a local primary school. He enjoyed playing with his younger sister and was a popular and energetic child.
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> 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.

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.

8. It was accepted that even on his admission to hospital, Jack was at risk of death from this condition (quantified as being in the range 4 – 20.8%). The expert evidence, however, revealed the clinical signs of septic shock which were present in Jack (cold peripheries, slow capillary relief time, breathlessness and cyanosis, lethargy and unresponsiveness). In addition, raised temperature, diarrhoea and breathlessness all pointed to infection being the cause.

9. The cause of death given after the post-mortem was systemic sepsis complicating a streptococcal lower respiratory infection (pneumonia) combined with Down's syndrome and the repaired hole in the heart. In those circumstances, the case for the Crown was that all three members of staff contributed to, or caused Jack's death, by serious neglect which fell so far below the standard of care expected by competent professionals that is amounted to the criminal offence of gross negligence manslaughter.

10. In respect of Dr. Bawa-Garba, the Crown relied on the evidence of Dr. Simon Nadel, a consultant in paediatric intensive care. He considered that when Jack, as a seriously ill child, was referred to her by the nursing staff, Dr. Bawa-Garba had responded, in part, appropriately in her initial assessment. His original view was that her preliminary diagnosis of gastro-enteritis was negligent but he later changed that opinion on the basis that the misdiagnosis did not amount to negligence until the point she received the results of the initial blood tests, which would have provided clear evidence that Jack was in shock. As to the position at that time, however, Dr. Nadel's evidence was that any competent junior doctor would have realised that condition. His conclusion was that had Jack subsequently been properly diagnosed and treated, he would not have died at the time and in the circumstances which he did.

11. To prove gross negligence, the Crown therefore relied on Dr. Bawa-Garba's treatment of Jack in the light of those clinical findings

and the obvious continuing deterioration in his condition which she failed properly to reassess and her failure to seek advice from a consultant at any stage. Although it was never suggested as causative, the Crown pointed to her attitude as demonstrated by the error as to whether a DNR ("do not resuscitate") notice applied to Jack.

12. In somewhat greater detail, in particular failings on which the prosecution case rested were, first what was said to be Dr. Bawa-Garba's initial and hasty assessment of Jack (at about 10.45 – 11 am) after receiving the results of the blood tests which ignored obvious clinical findings and symptoms, namely:

i) a history of diarrhoea and vomiting for about 12 hours;

ii) a patient who was lethargic and unresponsive;

iii) a young child who did not flinch when a cannula was inserted (to administer fluids);

iv) raised body temperature (fever) but cold hands and feet;

v) poor perfusion of the skin (a test which sees how long it takes the skin to return to its normal colour when pressed);

vi) blood gas reading showing he was acidotic (had a high measure of acid in his blood indicative of shock);

vii) significant lactate reading from the same blood gas test, which was extremely high (a key warning sign of a critical illness);

viii) the fact that all this was in a patient with a history which made him particularly vulnerable.

13. The second set of failings on which the prosecution rested related to subsequent consultations and the proper reassessment of Jack's condition. More particularly, these were that Dr. Bawa-Garba:

i) did not properly review a chest x-ray taken at 12.01 pm which would have confirmed pneumonia much earlier;

ii) 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 the failed to act upon them;

iii) failed to make proper clinical notes recording times of treatments and assessments;

iv) failed to ensure that Jack was given appropriate timeously (more particularly, until four hours after the x-ray);

v) 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).

14. Furthermore, at 4.30 pm, when the senior consultant, Dr. Stephen O'Riordan arrived on the ward for the normal staff/shift handover, Dr. Bawa-Garba failed to raise any concerns other than flagging the high level of CRP and diagnosis of pneumonia. She said Jack had been much improved and was bouncing about. At 6.30 pm, she spoke to the consultant a second time but did not raise any concerns….

16. The second detail is that for a short while, Dr. Bawa-Garba had a mistaken belief that Jack was a child for whom a decision had been made not to resuscitate: this was because she mistook Jack's mother for the mother of another child. Although this was said to be indicative of the degree of attention or care that Jack was receiving, it was underlined that this had no material or causative impact.

17. The case advanced on behalf of Dr. Bawa-Garba was that she was not at any stage guilty of gross negligence. Reliance was placed on the following details:

i) Dr. Bawa-Garba had taken a full history of the patient and carried out the necessary tests on his admission;

ii) At 11.30 – 11.45 am, Jack was showing signs of improvement as a result of having been given fluids (although it was agreed that this improvement had not been documented). There were also clinical signs of improvement from the second blood gas results which were available at 12.12 pm; Jack had been sitting up and laughing during the x-ray and reacted to having his finger pricked.

iii) Dr. Bawa-Garba was correct to be cautious about introducing too much fluid into Jack because of his heart condition.

iv) A failure in the hospital's electronic computer system that day meant that although she had ordered blood tests at about

10.45 am, she did not receive the blood test results from the hospital laboratory in the normal way and she was without the assistance of a senior house office as a consequence. The results were delayed despite her best endeavours to obtain them. She finally received them at about 4.45 pm.

v) Dr. Bawa-Garba had flagged up the increased CRP infection markers in Jack's blood to the consultant Dr. O'Riordan, together with the patient's history and treatment at the handover meeting at 4.30 pm. The consultant had overall responsibility for Jack.

vi) A shortage of permanent nurses meant that agency nurses (who included Nurse Amaro) were being used more extensively.

vii) Nurse Amaro had failed properly to observe the patient and to communicate Jack's deterioration to her, particularly as Dr. Bawa-Garba was heavily involved in treating other children between 12 and 3pm (including a baby that needed a lumbar puncture). The nurse also turned off the oxygen saturation monitoring equipment without telling Dr. Bawa-Garba and, at 3pm, when Jack was looking better, the nurse did not tell her about Jack's high temperature 40 minutes earlier or the extensive changing of the nappies.

viii) Dr. Bawa-Garba had prescribed antibiotics for Jack at 3pm as soon as she saw the x-ray (which she agreed she should have seen earlier), but the nurses failed to inform her that the x-rays were ready previously and then failed to administer the antibiotics until much after she had prescribed them (an hour later).

ix) At 7pm, the decision to transfer Jack to Ward 28 was not hers and she bore no responsibility for the administration of enalapril.

x) The mistaken belief that Jack was "DNR" was made towards the end of her 12/13 hour double shift and was quickly corrected. It was agreed that her actions in attending with the resuscitation team and communicating this made no difference, although that incident would have been highly traumatic for Jack's family.

18. Dr. Bawa-Garba gave evidence in her own defence and relied on her previous good character including positive character evidence. She had worked a double shift that day (12/13 hours straight) without any breaks and had been doing her clinical best, despite the demands placed upon her. She also called supportive expert advice (from Dr.

Samuels) to the effect that septic shock was difficult to diagnose and Jack's was a complicated case in which the symptoms were subtle and they were not all present. Finally, as intervening events, reliance was placed on the conduct of Nurse Amaro (including the delay in administering the antibiotics she prescribed), the problems with the computer system and the administration of the enalapril…

22. Dealing with the prosecution and defence cases on this issue, Nicol J summarised:

> "The prosecution say that while Jack was seriously ill on his arrival he had a real chance of survival and probably would have survived if he had been properly treated. At the very least, they say you can be sure he would not have died when and in the circumstances that he did if he had been properly treated by Dr. Bawa-Garba…
> …The prosecution accept that it is for you to decide whether the timing and circumstances of Jack's death were or may have been inevitable at some earlier point in the day [than when he was transferred to Ward 29] but they submit the negligence of Dr. Bawa-Garba prior to that point did significantly contribute to the timing and manner of Jack's death…
>
> 36…But she rightly recognised that the judge had correctly directed the jury that the prosecution had to show that what a defendant did or did not do was "truly exceptionally bad". Suffice to say that this jury was (and all juries considering this offence, should be) left in no doubt as to the truly exceptional degree of negligence which must be established if it is to be made out."

3. Nicol J said this in his sentencing remarks:

> "There was a limit to how far these issues could be explored in the trial, but there may be some force in the comment that yours was a responsibility that was shared with others.
>
> I turn to the mitigation which has been extremely capably advanced by your counsel. Hadiza Bawa-Garba, you were 35 at the time of this offence. You had wished to become a doctor since the age of 13. Medicine was your vocation. As a result of this offence, your career as a doctor will be over.
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> I received numerous testimonials that spoke in graphic terms of your skill as a doctor, your dedication to your patients and the high regard in which your colleagues held you. You were two years away from completing your training and being able to apply for posts as a

consultant. All that is over now. Like Isabel Amaro, you have no previous convictions.

Both of you have also had to wait some considerable time before these two proceedings have come to an end. I am told that in April 2012, the CPS wrote to both of you to say that you would not be prosecuted."

Annex 2

Timeline of legal proceedings

Timeline:	**18 February 2011**- Jack Adcock was admitted to Leicester Royal Infirmary and died later that same day. **28 February 2012-** Dr Bawa-Garba was interviewed by the police. **2 April 2012-** Referral made to the GMC by Medical Director of University Hospitals of Leicester following police involvement. The Trust informed us that a Serious Untoward Incident investigation had been conducted by the Trust. This resulted in Dr Bawa-Garba being made the subject of three month supervised training and taken off the on call rota. **11 April 2012-**CPS decision made not to prosecute Dr Bawa-Garba and communicated to the Adcock's. **7 June 2012-**GMC receive a referral from Jack Adcock's parents who complained of Jack's treatment. A GMC misconduct investigation was undertaken. **20 August 2012-** Rule 7 issued **2 November 2012-** Rule 7 response received from Dr Bawa Garba's Solicitors. Rule 8 decision postponed pending the inquest into Jack's death due to be held on 21 November 2012. **22-30 July 2013**- Inquest scheduled to take place, which was adjourned part-heard pending further enquiries. **July 2013-Dec 2014-**The CPS review decision to prosecute. Inquest placed on hold pending police/CPS decision. **18 December 2014-**Police inform the GMC Dr Bawa-Garba will be prosecuted for manslaughter. She is due to appear before Leicester Magistrates' Court on 23 January 2015.

	18 December 2014- Decision to refer to IOT made. **8 January 2015**- Interim order of suspension imposed. **24 March 2015-** Decision of IOT appealed to the High Court - suspension reduced to conditions **4 November 2015-** Dr Bawa-Garba convicted of gross negligence manslaughter. **13 November 2015**- In light of the conviction, IOT increase conditions to suspension. **14 December 2015-** Dr Bawa-Garba sentenced to 24 months custody suspended for 24 months. **16 December 2015-** Case is referred to MPT under Rule 5. **21 December 2015-** Appeal against conviction lodged. **12 July 2016-** MPTS list hearing 7-9 December 2016. **19 September 2016-** Leave to appeal refused by Single Judge. **29 November 2016-** Renewed application for leave to appeal to the full Court of Appeal is lodged. **30 November 2016**- Defence apply to postpone MPT hearing date - application unopposed by GMC and granted by MPTS. **8 December 2016-** Appeal refused Court of Appeal, Criminal Division, judgment. **21 December 2016**- MPT relisted for 20-22 February 2017. **20-22 February 2017**- MPT hearing - facts and impairment dealt with (adjourned part heard). **12-13 June 2017**- MPT reconvene to deal with sanction- 12 months (immediate) suspension imposed and interim

	order revoked. **30 June 2017**- GMC file s.40A appeal **7 December 2017**- s.40A Appeal hearing**.** **25 January 2018** – Divisional Court hands down judgment in the s.40A appeal. Appeal allowed, direction that the Doctor be suspended quashed and substituted with a direction that the Doctor's registration be erased from the register. **15 February 2018** – Dr Bawa Garba files Notice of Appeal at Court of Appeal seeking permission to appeal.