DETAILED CASE REVIEW FRONTSHEET **Reviewer:** [redacted]

NAME OF REGISTRANT	Hadiza Bawa-Garba
NAME OF REGULATOR	GMC/MPTS
TYPE OF CASE	Conviction
OUTCOME	12 months suspension with review
STATUTORY DEADLINE	18 August 2017 AND 18 Days remaining **The GMC has lodged an appeal under S40A of the Medical Act 1983**

Brief case summary	The registrant was convicted of manslaughter on the grounds of gross negligence. She was sentenced to 24 months imprisonment suspended for 24 months.
Summary of concerns	A DCR is being undertaken as this is a GMC appeal. This is a serious conviction: the issue to be considered is whether erasure was the only reasonable outcome in the circumstances of this case. Can it be shown that the Panel erred in its assessment of the public interest in concluding that suspension was the appropriate sanction in this case.
Why should the Authority consider challenging the decision?	The Authority may wish to give further consideration to this case because of the factual background and because of the GMC's ground of appeal in relation to diffidence. NB The Authority would be an interested party
Potential obstacles to successful challenge	The absence of clear failures on the part of the Panel when assessing whether public confidence would be negatively affected by a decision to suspend.
Conclusion on sufficiency in relation to public protection	I do not consider this is relevant.
Conclusion on sufficiency in relation to maintaining standards	There is the potential for this limb to be engaged.
Conclusion on sufficiency in relation to public confidence in profession	There is the potential for this limb to be engaged.

RECOMMENDATION

I am of the view that this is a borderline case and therefore the Panel's decision in this case may not be sufficient to protect the public (having regard to the criteria set out in section 29(4A) of the NHS Reform and Health Care Professions Act 2002 (as amended) and recommend that consideration be given to holding a section 29 Case Meeting. I have also identified one aspect of the GMC grounds that may be an issue on which the Authority wishes to engage in.

Background

1. In November 2015, the registrant was convicted for manslaughter on the grounds of gross negligence. In December 2015, she was sentenced to 24 months imprisonment suspended for 24 months. At the MPTS hearing it was alleged that she was impaired by reason of her conviction.

2. The registrant was the subject of a criminal prosecution because of her role in the treatment of Patient A[1] at Leicester Royal Infirmary (the Hospital) on 18 February 2011.

3. The Trust undertook an investigation into the death of Patient A and notified the GMC of the outcome in April 2012. The GMC opened an investigation but proceedings were delayed to allow for an inquest which started in July 2013 and was adjourned part heard. As a result of the evidence that was given at the inquest, the CPS re-considered its decision not to prosecute the registrant. Because of that criminal prosecution, the GMC inquiry was put on hold. The case was heard before Nottingham Crown Court in 2015 where she was found guilty by a jury of gross negligence. The registrant lodged an appeal against a point of law (which was unsuccessful) – that appeal was heard in December 2016.

4. The MPTS hearing commenced in February 2017 (20 to 22) and was then adjourned until June 2017. The decision as to sanction was announced on 13 June 2017. This is therefore the relevant date for the purposes of the Authority's review.

5. In February 2011, the registrant was a registrar specialising in paediatrics at the Hospital. She was in year 6 of her post graduate training and she held a certificate in Advanced Paediatric Life Support. It is a matter of fact that she had recently returned to work after a period of maternity leave – it is my understanding from reviewing the papers that no concern was raised as to her level of skills as a result of her absence from work.

6. Patient A was referred to the Hospital by his GP after a night of vomiting and diarrhoea. His GP had noted that he was dehydrated and slightly blue; that there was a high temperature, pulse towards the top of normal, respiratory rate was abnormally high, lethargy and that Patient A was using the abdominal muscles in order to breathe.

7. The registrant was the first doctor to see Patient A and the most senior doctor on the ward.

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[1] Referred to as Child J in the transcript

8. The Panel had sight of the sentencing remarks of the Nichol J[2] in which he made the following comments.

    a. he found that her initial treatment of Patient A was appropriate (by this he means her actions at 10.30/10.44 set out in the chronology);
    b. from 11.30, she did not pursue the investigation and treatment of Patient A's condition with the urgency, priority and attention it demanded.
    c. he found that she ought to have undertaken a third blood gas test as the second did not produce a reading for lactate and given the importance of this test, any concern around the discomfort of a further test should not have "stood in your way".3
    d. Nichol J referred to evidence of the prosecution expert that this was a "barn door obvious case" of sepsis and that the registrant ought to have realised that (even if her working diagnosis was not unreasonable) that sepsis was an alternative possibility which was so dangerous that urgent steps had to be taken to see if it could be properly excluded.
    e. The registrant's approach did not show that urgency – she did not see the x-ray results which were available from shortly after noon, until 3pm and it was another hour before Patient A received his first dose of antibiotic.
    f. Further she did not see the blood test results until 4pm. Nichol J acknowledged that there were issues with the IT system but that the delay was still too great.
    g. When the results were obtained, she did not realise their full import and further, at a meeting with the consultant which took place at about 4.30, she did not make sufficiently clear the seriousness of the patient's condition. He stated expressly that the registrant should have asked the consultant to see the patient but did not. Further, she did not seek further advice from the consultant on call or the PICU.
    h. When responding to the crash call she mistook Patient A for another patient who was not for resuscitation – Nichol J referred to this as "extraordinary" because this was such a serious step to take. She did this without checking the name of the patient concerned or otherwise positively identifying him.

9. The jury was directed that they could only convict the registrant if they were satisfied that the registrant was negligent and that her negligence significantly contributed to the patient's death or its timing; that any such negligence had to be gross or severe or, in other words, that the jury had to be satisfied that what she did or didn't do was truly exceptionally bad. He stated "by their verdict, the jury have shown that they were sure of all these matters".

10. In relation to sentencing, Nichol J said that the court is obliged to take account of the harm which has been caused by the offence. Sentence was passed on the

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[2] C1/3
[3] D1/5

basis that the registrant's failures led Patient A to die significantly sooner than he would otherwise have done. He identified that an aggravating feature of the case was that the victim was a young child. He also took into account the circumstances in which the offence took place. He states that

"The CAU of the LRI was a busy ward. It could not limit its intake. All children had to be seen, assessed and treated. There was no evidence that [the registrant] neglected [Patient A] because you were lazy or behaved for other selfish reasons. You both had other patients to attend to. The problem was that neither of you have [Patient A] the priority which this very sick boy deserved and in your case [the registrant], you were falsely reassured by the apparent improvement in [Patient A's] condition from the treatment which you did give him.

…I have decided that…the right length is two years. I've also decided that in light of all the circumstances of your offences and in light of the mitigation I have heard, those sentences will be suspended".

Chronology

10.30	registrant sees Patient A for the first time. Sister Taylor has applied an oxygen mask to assist with breathing. registrant prescribes a fluid bolus and arranged for a blood gas test Initial diagnosis is gastro-enteritis with moderate dehydration At around this time, she does not write in the patient's notes that Enalapril (a pre-admission medication) should not be administered
10.44	Blood gas test results available and show abnormal readings, in particular the lactate reading which was 11.4. The normal range is 0.4 to 2.3.
	registrant requests chest x-ray and for a repeat blood gas test.
12.30	X-ray becomes available but not seen by registrant
15.00	registrant reviews x-ray for the first time – she sees that there is an infection in the chest which triggers her to prescribe anti-biotics
16.00	Patient A administered first dose of anti-biotics registrant reviews second blood gas test results – she does not realise the significance of the results. This test result produced no reading for lactate and was not repeated as it should have been.
16.30	Meeting with Consultant but she does not ask him to review Patient A
19.00	Patient A's mother administers Enalapril

20.00	Crash call - registrant is one of the doctors that responds to the call. On entering the room, she confuses Patient A with another child patient who has a Do Not Resuscitate order in place and calls of resuscitation. Another doctor identifies the mistake and within 30 seconds to 2 minutes resuscitation continues.

11. The registrant attended the hearing and was represented but did not give any oral evidence. Witnesses were called on behalf of the registrant (Dr Jonathon Cusack and Dr Peter Barry).

Panel Decision

12. As noted above this was a conviction case. The registrant admitted the facts and the Panel took the certificate of conviction as conclusive evidence of the offence committed.

13. In its decision on impairment[4] the Panel made the following comments: -

a. It is clear that the registrant's actions fell far below the standards expected of a competent doctor and put Patient A at unwarranted risk of harm in that they led to Patient A dying significantly sooner that he otherwise would have;
b. The registrant's actions and resulting conviction brought the profession into disrepute and breached a fundamental tenet of the medical profession relating to good clinical care;
c. In relation to clinical matters, they were serious but were capable of being remediated. The Panel concluded that the risk of the registrant putting a patient at unwarranted risk of harm in the future is low.
d. It accepted the oral and documentary evidence presented on the registrant's behalf and noted that she had undergone significant remediation and reflection directly related to the concerns in this case;
e. It noted the certificates of training, positive supervisor reports, assessments and testimonials;
f. Her witnesses described her as an excellent doctor;
g. There have been no concerns prior to this event and she continued to practice without further incident after these events;
h. The Panel addressed the submission made by the GMC that the wholesale collapse of the standard of care provided by her came out of the blue and for no apparent reason/that the Panel could not have confidence in her that it would not happen again. The Panel stated that as it had accepted her evidence as to clinical remediation, the risk of another such

[4] Panel decision page 4

unexpected collapse "is no higher than for any other reasonably competent doctor"5;

i. In relation to the public interest, the Panel noted the conviction arose directly out of her medical practice, that it was a conviction for manslaughter and she received a suspended sentence that was still in force;
j. The Panel referred to the Fleischmann6 paragraph 54 and concluded that public confidence would be undermined in a finding of impairment was not made;
k. It noted that this was a case where her action fell so far below the standards to be expected resulting in a criminal conviction for manslaughter where you are still subject to a suspended prison sentence. An impairment finding was also required to promote and maintain proper professional standards and conduct for members of the profession.

14. The case was then adjourned and the Panel reconvened in June 2017 where it considered sanction. Counsel for the GMC submitted that erasure was the only appropriate outcome. Counsel for the registrant submitted that the appropriate sanction in this case was suspension.

15. The Panel heard further evidence from Dr Cusack at the sanction stage. He gave evidence about the multiple systemic failures identified in the Trust investigation following the events of 18 February 2011.

16. The Panel set out in the decision mitigating and aggravating factors. In relation to mitigating factors it noted that the registrant had a previously unblemished record as a doctor; she was of good character prior to the offence; this was her first shift in an acute setting following her return to work after a period of maternity leave; on the day in question she was covering CAU, the emergency department and the ward; the systemic failings and that here is no evidence of her actions being deliberate or reckless.

17. In relation to aggravating factors, the Panel noted that the patient was vulnerable by reason of his age and disability; her failings were numerous and continued over a period of time; there is no evidence that she has apologise to the family of patient A (although she expressed her condolences).

18. The Panel referred to the ISG in its decision on sanction; it reiterated the registrant's action marked a serious departure from GMP and contributed to the early death of Patient A; and also reminded itself of its findings on impairment (in summary that she had remediated the clinical concerns and this was a case about public confidence).

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[5] Panel decision, page 7, para 20
[6] CHRE v GDC and Fleischmann [2005] EWHC 87 (Admin)

19. The Panel placed weight on the evidence of Dr Cusask as to the multiple systemic failures and concluded that the registrant's failings, whilst falling far short of the standards expected and also being a causative factor in the early death of Patient A, took place in the context of wider failings.

20. It accepted the evidence of Dr Cusack, her supervisor, that the registrant had reflected deeply and demonstrated significant and substantial insight into her conversations with him. But as the Panel had not heard from the registrant herself, it could not conclude that she had complete insight.

21. The Panel applied the case of Bijl[7] noting that the Court in that case had said *"The Committee was rightly concerned with public confidence in the profession and its procedures for dealing with doctors who lapse from professional standards. But this should not be carried to the extent of feeling it necessary to sacrifice the career of an otherwise competent and useful doctor who presents no danger to the public in order to satisfy a demand for blame and punishment".*

22. The Panel concluded that public confidence could be achieved with a suspension order. The Panel noted that the registrant will remain subject to a suspended sentence until December 2017. It had regard to the ISG[8] which sets out the principle from Fleischmann. It determined that a period of 12 months was appropriate. The sanction will be in place until June 2018. The registrant's suspended sentence will have expired. A review hearing was ordered because the registrant had not shown complete insight and she had been out of practice for a significant period of time.

23. The Panel expressly considered whether erasure was appropriate[9]. In coming to its conclusion that erasure was not required, the Panel referred to the balance of the mitigating and aggravating factors and the ISG. It concluded that her actions were not fundamentally incompatible with continued registration because her actions were not deliberate or reckless; the registrant does not present a continuing risk to patient, and that she had remedied her failings.

Analysis

24. There are a number of cases that set out the approach to be applied by the Court when considered a challenge to a decision on sanction. In Khan[10] the Supreme Court gave the following guidance which applied the principles established in Marinovich[11] and Dad [12] which assists in our consideration.

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[7] Bijl v GMC [2001]UKPC 42
[8] Paragraph 113
[9] Panel decision, page 13 para 32.
[10] Khan v GPhC [2016] UKSC 64
[11] Marinovich v GMC [2002] UKPC 36
[12] Dad v GDC [2000] 1 WLR 1538

a. An appellate court must approach a challenge to the sanction imposed by a professional disciplinary committee with diffidence;
b. In a case such as the present (i.e. Khan: criminal conviction for behaving threateningly and abusively) the Committee's concern is for the damage already done or likely to be done to the reputation of the profession and it is best qualified to judge the measures required to address it;
c. A court can more readily depart from the Committee's assessment of the effect on public confidence of misconduct which does not relate to professional performance than in a case where the misconduct relates to it.

25. In my view, there are two issues to consider. First whether the Panel correctly identified the aggravating and mitigating factors and gave then appropriate weight or took into account irrelevant matters and then second, whether the Panel's reasoning was flawed, or the reasons inadequate, as to why an order for suspension was proportionate and an erasure order disproportionate. The ultimate question being, whether, in the circumstances of this case the only decision that a reasonable Panel could have imposed was erasure and whether this Panel can be shown to have erred in principle in its assessment of the public interest.

26. Although an obvious point, we must acknowledge in our consideration of the case that whilst this is a conviction case it is one that relates to clinical performance. Therefore, the judgement of this Panel will be afforded a high degree of deference by a Court.

27. I do not consider that the Panel has made any errors in setting out the principles it shall take into account when coming to its decision. I do not consider that there are any relevant factors that have been missed from the aggravating/mitigating factors list.

28. I do not consider that the Panel's conclusion that this registrant is not a risk to the public can be challenged or the conclusion that she has some insight (the Panel described her as not having complete insight). The Panel heard evidence from her supervisor and it accepted that evidence; there was no other evidence called before this Panel to suggest she currently posed a risk to patients. In the recent decision of Doree[13] the Court found that findings of insight are *"classically matters of fact and judgment"* for the Panel and provided the following guidance.

> *"In the first place, I do not accept that, in principle, a professional disciplinary committee may only reasonably find that a registrant has shown insight or remorse after he has himself given oral evidence to demonstrate it, and has made himself available for cross-examination or other questioning on that evidence – even if it has rejected his evidence on some or all of the*

[13] PSA v HCPC and Doree [2017] EWCA Civ 319

allegations he faced. Whether a registrant has shown insight into his misconduct, and how much insight he has shown, are classically matters of fact and judgment for the professional disciplinary committee in the light of the evidence before it. Some of the evidence may be matters of fact, some of it merely subjective. In assessing a registrant's insight, a professional disciplinary committee will need to weigh all the relevant evidence, both oral and written, which provides a picture of it. This may include evidence given by other witnesses about the registrant's conduct as an employee or as a professional colleague, and, where this is also relevant, the quality of his work with patients, as well as any objective evidence, such as specific work he has done in an effort to address his failings. Of course, there will be cases in which the registrant's own evidence, given orally and tested by cross-examination, will be the best evidence that could be given, and perhaps the only convincing evidence. And such evidence may well be more convincing if given before the findings of fact are made. But this is not to say that in the absence of such evidence a professional disciplinary committee will necessarily be disabled from making the findings it needs to make on insight, or bound to find that the registrant lacks it"

29. I note the Panel has not referred to the decision of Bolton[14] which highlights the essential purpose of sanctions in such proceedings which is to maintain the reputation of the profession and that this carries greater weight than the fortunes of any individual. It is not clear how the Panel would have undertaken the exercise of balancing the principles from Bolton and Bijl.

30. I do not consider that the Panel has fallen into error in placing weight on the fact that there had been systemic failures when considering the case in context.

31. The ISG provides the following guidance to the Panel –

    a. The Panel may erase a doctor from the medical register in any case where this is the only means of protecting the public;
    b. Erasure may be appropriate even where the doctor does not present a risk to patient safety but where this action is necessary to maintain confidence in the profession (eg where he has shown blatant disregard for the safeguards designed to protect members of the public…)
    c. Erasure may be indicated where there has been a particularly serious departure from the principles set out in GMC where the behaviour is fundamentally incompatible with being a doctor; where there has been a deliberate or reckless disregard for the principles set out in the GMP; doing serious harm to others either deliberately or through incompetence and particularly where there is a continuing risk to patients

32. This is a very borderline case, where there were competing aspects of the public interest and it is certainly possible to argue that this was a case where erasure

[14] Bolton v Law Society [1994] 1 WLR 512

was a response that was available to the Panel taking into account the guidance offered by the ISG and the principles established in case law. However, it is not clear to me that this was the only outcome.

33. I do not consider that the Panel's reasoning is flawed as to why an order for suspension was proportionate and that an erasure order was disproportionate.

The GMC grounds of appeal

34. I set out below a summary of the GMC grounds of appeal.

35. The GMC acknowledges that the Court will usually approach the issue of sanction, where this is based on as assessment of what is required to maintain public confidence and proper standards in the profession with diffidence but that in this case the Court should balance this against
    a. Fatnani does not encourage diffidence in an appeal brought by the GMC (as opposed to one brought by the doctor)
    b. The MPT was not required to apply its expertise about clinical matters in the present case since the substantive determination on the standard of conduct had already been made in the criminal court
    c. The MPT did not form its own impression of the registrant character and insight since she did not give live evidence.

36. The Panel was wrong to place weight on the evidence of systemic failures as this was going behind the jury's verdict.

37. In relation to remediation, such factors are relevant to the question of risk but are of limited relevance to the public confidence in the profession and the need to maintain professional standards.

38. Matters of personal mitigation are less relevant in professional conduct settings in the public interest.

39. I have considered the grounds of appeal.
    a. It appears that the GMC is seeking to create a line of case law which establishes a distinction in how the courts approach appeals by a regulator and a registrant. This may be a factor that the Authority wishes to consider further.
    b. In my view the GMC is seeking to make a distinction between this case, which it seeks to define as a "conviction case" only and cases of misconduct which are of a clinical nature in order to support their argument that less deference is owed to the Panel's expertise. I am not clear that this argument is sustainable. In any event, the Panel was required to consider the underlying facts of the conviction and have not sought to minimise them.
    c. I have addressed the issue of insight and the guidance from Doree above.

d. In my view the Panel was not seeking to go behind the conviction or minimising it.
e. I agree that matters of remediation carry less weight/ are of secondary importance in public confidence cases, but it is not clear to me that the Panel has placed too much weight on these issues. Further, current risk status is a relevant factor to whether erasure was mandated (see ISG).
f. I agree with the statement as to personal mitigation, but the GMC has not identified which factors it refers to. This is not a case where the Panel has stated in its determination that it is placing the interests of the doctor/ her family above those of the public interest.

Recommendation

40. In my view, the Authority may wish to give further consideration to this case because of the factual background (despite the fact I have not identified any areas of major concern) because of the public interest in this case and because of the GMC's ground of appeal in relation to diffidence.

[redacted]

31 July 2017