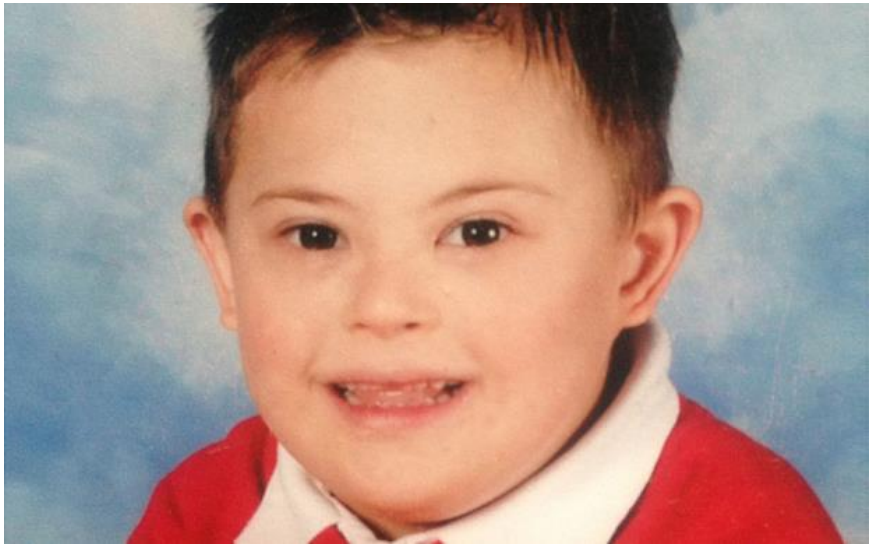
Gross Negligence Manslaughter & Dr Bawa-Garba: Just Culture?

Steven Shorrock

Jack Adcock

- Jack Adcock was a 6 year old boy.
- Jack had Down's syndrome and a known heart condition but was doing well and living a full life



Jack Adcock

- Referred by GP to Leicester Royal Infirmary on morning of 18 February 2011 for severe vomiting, diarrhoea and breathing difficulties
- He collapsed at 7.45pm
- A paediatric arrest team was summoned
- He had had a heart attack brought on by “septic shock” due to a virulent form of pneumonia
- He died at 9.20pm of a cardiac arrest as a result of sepsis (11 hours after being admitted)

Dr Hadiza Bawa-Garba

- Dr Hadiza Bawa-Garba (38) was a specialist registrar in year six of her postgraduate training (ST6).
- Moved to England from Nigeria in 1994 to be privately educated at an international college
- Qualified in Medicine in 2003 after degree in Psychology and Pharmacology

What went wrong

- Bawa-Garba diagnosed Jack with gastroenteritis and moderate dehydration, but he was turning blue around the lips and suffering from 'very low' oxygen levels
- On review of the first blood results, she did not appreciate the full significance of elevated lactate
- An X-ray showing pneumonia not acted on for 4 hours
- He was then given the wrong antibiotic
- She did not register abnormally high levels of urea and creatinine indicated abnormal kidney function
- Andrew Thomas QC said Bawa-Garba failed to offer clear direction to her team, or call on the assistance of a senior consultant (e.g., during PM handover meeting)

“It was not just a momentary lapse. The prosecution say that Jack’s care was neglected over a protracted period of time: her failings were compounded by a failure to go back and reassess Jack despite clear indications that his underlying condition was continuing. These were not just simple breaches of duty, but really serious breaches amounting to gross negligence.”

Andrew Thomas QC

What went wrong - Nurses

- Prosecutor Andrew Thomas QC said **Nurse Taylor**, who was the first to see Jack, should have *“realised that he was seriously ill and required treatment as a medical emergency”*
- Thomas said **Nurse Amaro**, who trained in Portugal and was registered as an adult nurse, *“wrongly indicated that his case was ‘low-level concern’, despite the fact Jack needed high levels oxygen”.*
- Thomas said Amaro’s record-keeping was *“woefully incomplete”* and failed to monitor Jack’s vital signs.

Contextual and Systemic Issues

Competency and experience

- Bawa-Garba had just returned from 13 months' maternity just a month earlier
- Bawa-Garba had little experience of working on a child assessment unit

Supervision and staffing

- The **consultant** in charge Dr Stephen O' Riordan was was lecturing at a university outside the city
- The **registrar** covering the children's assessment unit was not in the hospital
- A **Senior House Officer (SHO)** and a Foundation Doctor had rotated to Paediatrics only that month
- Due to an IT failure, the SHO was delegated to phone for results from noon until 4pm
- Bawa-Garba was effectively covering for the consutant, registrar and SHO

Equipment

- A hospital IT system was down for the morning
- The results alerting system never came back online

Workload, Multitasking and Distraction

- Bawa-Garba was solely in charge of the emergency department and acute Children's Assessment Unit
- Covering 6 hospital wards across 4 floors
- Dozens of sick children were directly under her supervision
- Bawa-Garba had to cover 3 other professionals
- The situation would have been highly demanding even with proper staffing
- Bawa-Garba was on shift for many hours, making dozens of critical decisions on complex or urgent cases

Workload, Multitasking and Distraction

- Other complex and urgent interventions included a lumbar puncture and stabilising a child experiencing epileptic fits.
- Tasks would have included taking the calls of GPs, providing advice to other clinical staff, making diagnoses, offering reassurance to worried patients and parents,

Communication and handover

- Bawa-Garba was supposed to have an induction
- This would cover the wards, the patients and how to manage workflow, and to integrate all of Jack's information into her decision-making
- For staffing reasons the induction didn't happen.
- A "crash bleep" as a child went into cardiac arrest meant that she missed the morning handover
- During this time, she performed a lumbar puncture, which saved a child's life

Rest, Nutrition, and Hydration

- She had had no break in 12 hours (13 hour shift)

Other complications

- Enalapril had been administered without the knowledge of Bawa Garba
- Jack took Enalapril routinely
- Enalapril is a blood-pressure medication, and can lead to cardiac arrest

Resuscitation

- During resuscitation, Jack was confused with a different patient she had treated that day marked “do not resuscitate” (DNR)
- The other child was a two year who had been discharged home earlier that day
- She stopped life-saving treatment on Jack
- She did not ask the name of the patient
- It was only restarted when a first-year doctor Dr Lakhani re-read the notes and said she could not see a DNR entry
- This was not regarded as a factor in the outcome

- QC Thomas said that Bawa-Garba's mistaking of Jack for another patient who was marked *"do not resuscitate" was a remarkable error, adding that while Jack was "beyond the point of no return"* and that resuscitation was futile, it suggested Bawa-Garba had not given the youngster sufficient care.
- Thomas said: *"During this critical period an event occurred which you may think is powerful evidence of Dr Bawa-Garba's performance that day. When she came into the bay, almost immediately she called the resuscitation off. She told the other doctors Jack had been marked down as do not resuscitate earlier in the day."*
- Thomas then asked: *"When you arrived, you could see the face of the little boy being resuscitated?"* The doctor said: *"I cannot recall whether I saw the face or not. I could see a small room, an oxygen mask, it's an emotionally charged environment."*
- Thomas said: *"Is it symptomatic of your behaviour that day that you rushed to a decision without checking?"* She said: *"It's not that. It's a reflection of how long I had been working without a break."*

Reflective Practice

- Bawa-Garba talked through the case with her consultant She stated she could have done better
- Elements of her e-portfolio were included in materials seen by expert witnesses
- She met duty consultant Dr O'Riordan to discuss the incident and learnings. Dr O'Riordan's own notes formed part of his witness evidence

Revealed: how reflections were used in the Bawa-Garba case

31 January 2018

Jaimie Kaffash and Julia Gregory investigate whether doctors should be worried about their reflective practice

Safety Investigation

- A serious-incident inquiry concluded that there wasn’t a single root cause for the death
- The Inquiry highlighted 23 recommendations for systemic reform and 79 actions to minimise risks to patients

Court case

- The jury heard three weeks of evidence concerning alleged breached their legal duty of care to the boy
- 10-2 majority guilty verdict after nearly 25 hours
- Taylor was acquitted
- 4 Nov 2015 - Bawa-Garba and Amaro convicted
- 14 Dec 2015 - Bawa-Garba and Amaro given two-year suspended sentences.
- Bawa-Garba's failures *"were not simply honest errors"* according to the Prosecution. *"The prosecution say their conduct was grossly negligent: truly, exceptionally bad; amounting to a criminal offence."*
- 8 Dec 2016 - Appeal against sentence denied Appeal.

At the start of the trial, Andrew Thomas QC, prosecuting, said: *“Under their care, Jack’s condition needlessly declined to a point where, before he had been transferred to the next ward, he was effectively beyond the point of no return. If the defendants had recognised the severity of Jack’s illness and the fact he was in shock, if they had re-assessed him and acted on the findings, the risk of death would have been very greatly reduced.”*

GMC Medical Practitioners Tribunal Service tribunal

- 13 June 2017 - MPTS suspended Bawa-Garba for 12 months, after taking account of system failures that contributed to Jack's death
- MPTS rejected an application from the GMC to strike her off the register
- Nicola Adcock: Bawa-Garba had yet to apologise
- MPTS found that although she had 'expressed condolences' to Jack's family, they had seen no evidence to suggest she had apologised
- *"balancing the mitigating and aggravating factors, the tribunal concluded that erasure would be disproportionate."*

High Court

- The GMC went to the High Court to appeal its own Tribunal (the MPTS)
- 25 Jan 2018 - High Court ruled that Bawa Garba must be struck off the UK medical register to maintain public confidence
- The MPTS had come to a less severe view of her culpability, but in doing so they undermined the verdict of the jury

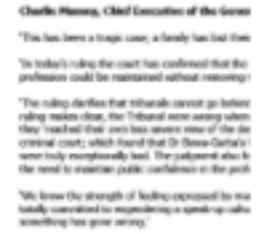
“The Tribunal did not respect the verdict of the jury as it should have. In fact, it reached its own and less severe view of the degree of Dr Bawa-Garba’s personal culpability.”

Lord Justice Ouseley

Jeremy Hunt 
@Jeremy_Hunt

Follow

Wouldn't be appropriate for me as Govt Minister to criticise a court ruling, but deeply concerned about possibly unintended implications here for learning & reflective practice in e-journals. Am also totally perplexed that GMC acted as they did: patient safety must be paramount



Shaun Lintern @ShaunLintern
GMC statement. Essentially panels are bound by earlier criminal courts. But the issue here is that the original court didn't hear all the evidence re systemic failings. Whatever the rights and wrongs in this case, the wider impact could be serious #BawaGarba

Show this thread

4:35 PM - 25 Jan 2018

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TIMELINE OF THE BAWA-GARBA CASE

FEBRUARY 2011

6 year old **Jack Adcock** dies from sepsis at Leicester Royal Infirmary

DECEMBER 2014

Bawa-Garba and two nurses, including **Theresa Taylor,** are charged with gross negligence manslaughter

NOVEMBER 2015

Bawa-Garba is found guilty and given a two year suspended sentence. Taylor is cleared

AUGUST 2016

The nurse also convicted in the case, **Isabel Amaro,** is struck off

DECEMBER

Bawa-Garba is denied permission to appeal against her manslaughter conviction

JUNE 2017

Medical practitioners tribunal suspends Bawa-Garba for 12 months, saying that "erasure would be disproportionate"

JANUARY 2018

High Court rules that Bawa-Garba must be struck off the UK medical register to maintain public confidence in the profession

The Aftermath

The GMC pursued Hadiza Bawa-Garba – and is losing doctors' respect

Loss of confidence in the General Medical Council will diminish its ability to protect patients and support medics

If Hadiza Bawa-Garba worked in the US she would still be a doctor

In the individualistic US medical errors are blamed on systems but in the collectivist NHS individuals are blamed for errors

Legal bar for convicting healthcare professionals of manslaughter is 'too low', medical organisation warns

Doctors 'significantly overinvestigated' for manslaughter, say medico-legal experts

By Nick Bostock on the 27 March 2018

The bar should be raised to ensure that doctors are only invesigated for gross negligence manslaughter (GNM) in cases that are the 'medical equivalent of driving down the wrong side of the motorway', the Medical Defence Union(MDU) has warned.

News › Health

Dr Bawa-Garba: Doctors threaten to boycott their appraisals over treatment of trainee paediatrician

Staff fear they could face legal action if they admit mistakes

Harriet Agerholm | @HarrietAgerholm | Thursday 1 February 2018 18:30 GMT | 3 comments

Aftermath - GMC Guidance

- The GMC issued guidance following this case, that where doctors find an unsafe situation they are to report it but continue delivering service

Aftermath - Petition and Appeal

- More than 8,000 doctors signed a petition stating that the case will only “lessen our chances of preventing a similar death”
- An online appeal raised £366,000 from 11,079 supporters for legal fees

News › Health

Hadiza Bawa-Garba: Medics raise £200,000 legal fund for junior doctor struck off over six-year-old's death

Decision to push for Dr Bawa-Garba to be stripped of her medical licence following mistakes in under pressure hospital has wide-ranging impact for NHS, doctors warn

Alex Matthews-King Health Correspondent | Monday 29 January 2018 14:01 GMT | 237 comments

“For large numbers of the medical profession who have read this account, the clinical circumstances surrounding Jack’s death sound exceptionally horrific, with Dr Bawa-Garba struggling against all odds to keep her young patients safe and undertaking the roles of 3 or 4 doctors in the absence of her supervising clinical consultant”

Independent Legal Opinion on Dr Bawa-Garba Case

by **Dr Moosa Qureshi, Dr James Haddock, Dr Chris Day**

Health Lawyers: Tim Johnson/law London, United Kingdom

Dr Moosa Qureshi, Dr James Haddock, Dr Chris Day

We are doctors that have been opposing attempts to argue junior doctors out of statutory whistleblowing protection.

Funded

on 26th January 2018

£366,289

pledged by 11080 people

Share on Facebook

https://www.crowdjustice.com/case/help-dr-bawa-garba/

"The criminalisation of medical error when events are considered singularly rather than as a part of a highly complex system is going to seriously impede learning"

Dr Jonathan Cusack (Bawa-Garba's consultant neonatologist, who gave evidence in her defence at the criminal trial and the MPTS hearing)

Appeal

- Feb 2018 - Bawa-Garba instructed barristers James Laddie QC, who specialises in employment and discrimination law, and Sarah Hannett to represent her. She may also appeal her 2015 conviction for gross negligence manslaughter
- 28 March 2018 - Dr Hadiza Bawa-Garba granted leave to appeal the High Court decision that allowed the GMC to erase her from the register against the MPTS findings

PTA Template 269D1 - OCT16 - Second Appeal (GS:02.12.16)

IN THE COURT OF APPEAL, CIVIL DIVISION
APPLICATION FOR A SECOND APPEAL

REF: **C1/2018/0356**

Her Majesty's Court of Appeal
28 MAR 2018 [SEAL]

Dr Hadiza Bawa-Garba –v– General Medical Council

Decision on an application for a second appeal. The Judge will not give permission unless he or she considers that (a) the appeal would i) have a real prospect of success; and ii) raise an important point of principle or practice; or (b) there is some other compelling reason for the Court of Appeal to hear it.

ORDER made by the Rt. Hon. Lord Justice Simon

On consideration of the appellant's notice and accompanying documents, but without an oral hearing, in respect of an application for permission to appeal

Decision: granted, refused, adjourned. An order granting permission may limit the issues to be heard or be made subject to conditions.

Granted

Reasons

The grounds meet the second appeal test in all respects. Having rejected the respondent's argument that a gross negligent manslaughter conviction should lead to erasure in the absence of (truly) exceptional circumstances, it is properly arguable that the Divisional Court applied an equivalent test in allowing the respondent's appeal.

Information for or directions to the parties

The grounds of appeal should be disclosed to the British Medical Association

This case falls within the Court of Appeal Mediation Scheme automatic pilot categories*. Yes ☐ No ☒

Recommended for mediation Yes ☐ No ☐

If not, please give reason:

Where permission has been granted, or the application adjourned

a) time estimate (excluding judgment) 1 day

b) any expedition the case should be listed for hearing before the end of July 2018

HER MAJESTY'S COURT OF APPEAL E&W

Signed: P Jonathan Simon

Date: 23 March 2018

By the Court

Notes

(1) Permission to appeal will only be granted in respect of second appeals if the court considers that:
(a) the proposed appeal would raise some important point of principle or practice; or
(b) there is some other compelling reason for the relevant appellate court to hear the appeal.
In respect of second appeals from the county court or High Court, see CPR 52.7.
In respect of appeals from the Upper Tribunal, see Article 2 of the Appeals from the Upper Tribunal Order 2008 (SI 2008/2834).

(2) Where permission to appeal has been refused on the papers, that decision is final and cannot be further reviewed or appealed. See rule 52.5 and 54(4) of the Access to Justice Act 1999.

(3) Where permission to appeal has been granted you must serve the proposed bundle index on every respondent within 14 days of the date of the Listing Window Notification letter and seek to agree the bundle within 49 days of the date of the Listing Window Notification letter (see paragraph 21 of CPR PD 52C).

Long term unintended consequences

- May drive recruitment away from “at risk” specialties such as emergency medicine and paediatrics
- Implications for learning and reflective practice

News › Health

Dr Bawa-Garba: Doctors threaten to boycott their appraisals over treatment of trainee paediatrician

Staff fear they could face legal action if they admit mistakes

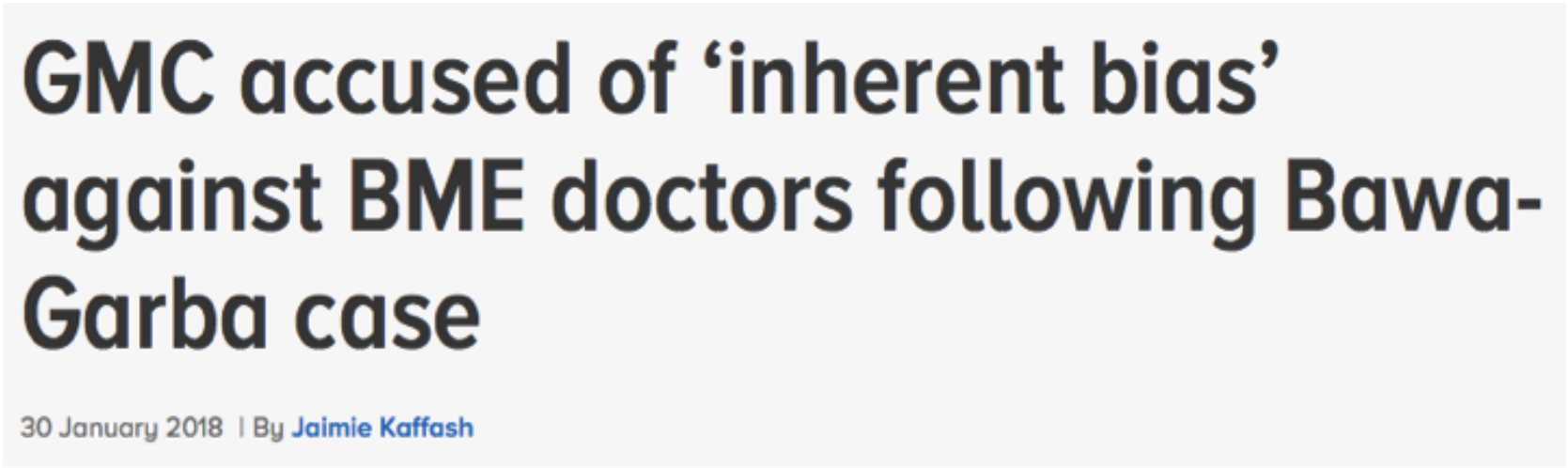
Harriet Agerholm | @HarrietAgerholm | Thursday 1 February 2018 18:30 GMT | 3 comments

Public Interest Issues

- Would the public allow a doctor convicted of manslaughter to treat children?
- What are the rights of patients to be informed that they are being treated in substandard conditions? Should a doctor inform patients?

Public Interest Issues

- Why not the same outcry on conviction?
- What is the role of gender and race? (BME doctors born, educated and went to medical school in UK have about a 30% greater chance of having a sanction)



GMC accused of 'inherent bias' against BME doctors following Bawa-Garba case

30 January 2018 | By Jaimie Kaffash

NHS Improvement

A just culture guide

Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents

This guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. Action singling out an individual is rarely appropriate - most patient safety issues have deeper causes and require wider action.

The actions of staff involved in an incident should **not** automatically be examined using this **just culture guide**, but it can be useful if the investigation of an incident begins to suggest a concern about an individual action. The guide highlights important principles that need to be considered before formal management action is directed at an individual staff member.

An important part of a just culture is being able to explain the approach that will be taken if an incident occurs. A just culture guide can be used by all parties to explain how they will respond to incidents, as a reference point for organisational HR and incident reporting policies, and as a communication tool to help staff, patients and families understand how the appropriate response to a member of staff involved in an incident can and should differ according to the circumstances in which an error was made. As well as protecting staff from unfair targeting, using the guide helps protect patients by removing the tendency to treat wider patient safety issues as individual issues.

Please note:

- **A just culture guide** is not a replacement for an investigation of a patient safety incident. Only a full investigation can identify the underlying causes that need to be acted on to reduce the risk of future incidents.
- **A just culture guide** can be used at any point of an investigation, but the guide may need to be revisited as more information becomes available.
- **A just culture guide** does not replace HR advice and should be used in conjunction with organisational policy.
- **The guide** can only be used to take one action (or failure to act) through the guide at a time. If multiple actions are involved in an incident they must be considered separately.

Start here - Q1. deliberate harm test

1a. Was there any intention to cause harm?

Yes → **Recommendation:** Follow organisational guidance for appropriate management action. This could involve: contact relevant regulatory bodies, suspension of staff, and referral to police and disciplinary processes. Wider investigation is still needed to understand how and why patients were not protected from the actions of the individual. → **END HERE**

No go to next question - Q2. health test

2a. Are there indications of substance abuse?

Yes → **Recommendation:** Follow organisational substance abuse at work guidance. Wider investigation is still needed to understand if substance abuse could have been recognised and addressed earlier. → **END HERE**

2b. Are there indications of physical ill health?

2c. Are there indications of mental ill health?

Yes → **Recommendation:** Follow organisational guidance for health issues affecting work, which is likely to include occupational health referral. Wider investigation is still needed to understand if health issues could have been recognised and addressed earlier. → **END HERE**

If No to all go to next question - Q3. foresight test

3a. Are there agreed protocols/accepted practice in place that apply to the action/omission in question?

3b. Were the protocols/accepted practice workable and in routine use?

3c. Did the individual knowingly depart from these protocols?

If No to any → **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. → **END HERE**

If Yes to all go to next question - Q4. substitution test

4a. Are there indications that other individuals from the same peer group, with comparable experience and qualifications, would behave in the same way in similar circumstances?

4b. Was the individual missed out when relevant training was provided to their peer group?

4c. Did more senior members of the team fail to provide supervision that normally should be provided?

If Yes to any → **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. → **END HERE**

If No to all go to next question - Q5. mitigating circumstances

5a. Were there any significant mitigating circumstances?

Yes → **Recommendation:** Action directed at the individual may not be appropriate; follow organisational guidance, which is likely to include senior HR advice on what degree of mitigation applies. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. → **END HERE**

If No

Recommendation: Follow organisational guidance for appropriate management action. This could involve individual training, performance management, competency assessments, changes to role or increased supervision, and may require relevant regulatory bodies to be contacted, staff suspension and disciplinary processes. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. → **END HERE**

improvement.nhs.uk

Based on the work of Professor James Reason and the National Patient Safety Agency's Incident Decision Tree

Supported by: Academy of Medical Royal Colleges; AIMA; CareQuality Commission; General Medical Council; National Guardian Freedom to Speak Up; NMC Nursing & Midwifery Council; NHS England; Royal College of Nursing

collaboration trust respect innovation courage compassion

Review of GNM in NHS

- The GMC announced a review of how gross negligence manslaughter is applied to medical practice
- England's health secretary, Jeremy Hunt, has announced a review of the application of gross negligence manslaughter in the NHS.
- Prof Sir Norman Williams, former president of the Royal College of Surgeons, will lead the review