Neutral Citation Number: [2016] EWCA Crim 1841

Case No: 201505475B1

IN THE COURT OF APPEAL (CRIMINAL DIVISION)
ON APPEAL FROM THE CROWN COURT AT NOTTINGHAM

Mr Justice Nicol

T20157629

Royal Courts of Justice

Strand, London, WC2A 2LL

Date: 08/12/2016

Before :

THE PRESIDENT OF THE QUEEN'S BENCH DIVISION

(SIR BRIAN LEVESON)

MR JUSTICE OPENSHAW

and

MR JUSTICE MALES

- -

Between :

HADIZA BAWA-GARBA **Appellan**

- and -

THE QUEEN **Respond**

- -

- -

Zoe Johnson QC and **Julian Woodbridge**

(instructed by **RadcliffesLeBrasseur, London**) for the **Appellant**

Andrew Thomas QC and **Matthew Corbett-Jones**

(instructed by **Crown Prosecution Service**) for the **Respondent**

Hearing date : 29 November 2016

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Judgment Approved

Sir Brian Leveson P :

1.
On 4 November 2015, in the Crown Court at Nottingham before Nicol J and a jury, Dr Hadiza Bawa-Garba was convicted of manslaughter (by gross negligence). On 14 December 2015, she was sentenced to a term of two years' imprisonment the operation of which was suspended for two years. She was also ordered to pay £25,000 towards the costs of the prosecution. A nurse on duty at the time (Isabel Amaro) was also convicted of the same offence; the ward sister (Theresa Taylor) was acquitted.

2.
Dr Bawa-Garba now renews her application for leave to appeal against conviction after refusal by the single judge (Edis J). In the event, the Crown were directed to attend on the basis that, if leave was granted, the case would be considered on the basis that it constituted the hearing of the appeal.

The Facts

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

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

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

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

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 it 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 light of those clinical findings and the obvious continuing deterioration in his condition which she failed to properly 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, the 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 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 then 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 antibiotics 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.

15.
Before parting from the history, two further details need to be added, neither of which caused Jack's death. First, having been transferred to a ward (Ward 28) and, thus, out of Dr Bawa-Garba's care, Jack received what had been his usual dose of enalapril (for his unrelated conditions) from his mother shortly before he fatally collapsed. This was entirely understandable and known to the medical staff on the ward. In fact, Dr Bawa-Garba had deliberately not prescribed enalapril as she was aware

(accurately) that it could lower blood pressure, particularly in a dehydrated child. It was agreed at trial that enalapril should not have been given and may have contributed to Jack's death although it did not cause his death.

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 10.45am, 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 officer as a consequence. The results were delayed despite her best endeavours to obtain them. She finally received them at about 4.15pm.

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 4.30pm. 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 3 pm, 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 7 pm, 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 a "DNR" was made towards the end of her 12/13 hour double shift and was very 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 evidence (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.

The Approach of the Trial Judge

19.
The essential issue that has arisen in the case concerned causation. Early on in his directions of law, Nicol J said:

"Each defendant will be guilty of the offence only if her gross negligence caused or significantly contributed to Jack's death. … In one sense, Jack died because of the infection which had spread through his body. … What the prosecution has to show is that the negligence of the defendant whose case you are considering at least significantly contributed to Jack's death. You have heard that even if everything that the Crown say ought to have been done for Jack had been done, he might not ultimately have survived but the Crown will have satisfied this element of the offence if they have made you sure that Jack died significantly sooner because of the negligence of the defendant whose case you are considering. Once again, how big a contribution has to be in order to qualify as significant is left to your good sense, although it must be more than trivial or minimal. So if you decide that the defendant in question was grossly negligent in her care of Jack, you must ask yourselves whether the defendant's failure to treat him in a proper way significantly contributed to Jack's death or led to him dying significantly sooner than he would otherwise have done."

20.
As for the administration of enalapril, the judge left to the jury whether that was or may have been the sole cause of death (on the basis that if it was, no defendant was guilty) and went on:

“Likewise, the Crown would have failed to prove the case against any of the defendants if the effect of the enalapril was or may have been so dominant that any acts or omissions of the defendants did not make a significant contribution to Jack dying as and when he did. But if you are still sure that the defendant whose case you are considering was grossly negligent and that her negligence did significantly contribute to Jack’s death or timing, then it would be immaterial that the enalapril may also have played a part, even a significant part, in Jack’s death or its timing.”

21.
He dealt with what was described as “the point of no return” i.e. the time after which Jack was more likely to die than to survive and, thus, after which the jury could not be sure that any gross negligence was causative of death. He described Dr Nadel’s evidence that he could not be sure that Jack had not passed the point of no return at 3.00, 4.00 or 5.00 pm because he had no information to work from apart from the lack of oxygen saturation reading after 2.30 which was why it was so important to continually reassess what the clinical situation was.

22.
Dealing with the prosecution and defence cases on this issue, he 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 28] 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.

…

[The defence case is that Dr Bawa-Garba] accepts that she did not spot signs of renal failure but if by then Jack had passed the point of no return, neither this nor any subsequent negligence could have played a significant part in Jack’s death or its timing.

The DNR incident was a mistake but it made no contribution to Jack’s death. It is argued on her behalf that you cannot be sure that Jack had not passed the point of no return at some stage even earlier than 4.00 pm. Again, if that be right, no subsequent negligence, if that is what you find it was, could be causative of Jack’s death.”

The Appeal

23.
Zoe Johnson QC for Dr Bawa-Garba argues that it was an error in law to direct the jury that the prosecution had proved its case if the jury were sure that Jack died significantly sooner because of the negligence of the defendant. That was so particularly because the phrase “significantly sooner” was never explained to the jury in the context of septic shock and those omissions. Rather, she argues, the jury had to be sure that the treatment would have saved or significantly prolonged Jack’s life. Thus, the test was inverted and should have required the jury to be sure that there would have been significant prolongation of Jack’s life if the treatment contended for had been given. It was not sufficient to show that there was an opportunity lost which might have prolonged life.

24.
Andrew Thomas QC for the Crown submits that the direction of law was legally correct and that, in all material respects, the direction was to precisely the same effect as that which Ms Johnson advances. To be sure that Jack died significantly sooner because of gross negligence is the same as being sure that competent treatment would have saved or significantly prolonged his life.

25.
Before dealing with the merits of the argument, it is worth addressing a preliminary point taken by Mr Thomas to the effect that the direction had been discussed and agreed with counsel before it was delivered. Entirely sensibly in a case of this complexity, Nicol J not only shared his directions of law with counsel (which is usually essential) but also his summary of the issues and facts. It is a course which, in appropriate cases, we encourage and it is important to underline that agreement does not prevent counsel from later arguing that the direction (even one which might have been agreed) is wrong. Where the law mandates specific directions of law, counsels' agreement cannot alter the position and render a verdict safe that is, in fact, unsafe.

26.
Agreement is not, however, unimportant because if counsel on both sides are content that what the judge intends to say reflects the law as it applied to the issues that had been disclosed by the case, a good reason will have to be advanced for the change in mind and where a direction is discretionary, the fact that it has been agreed (which could be for many forensic reasons) might be determinative (cf. R v Hunter [2015] EWCA Crim 631 at [98]). Thus, in this case, Ms Johnson did raise one aspect of causation (namely whether the jury should be given more assistance about what was meant by the word 'significantly') with the judge. When the judge observed that he had included the phrase that it had to "be more than trivial or minimal" and said that to elaborate might make the matter become complex and unhelpful, Ms Johnson did not disagree. In particular, she did not press an alternative formulation. Having said that, the proper formulation of the necessary causative link was essential and we therefore pass to the merits of the argument.

27.
Both sides made reference to the relevant authorities which it is worth shortly reviewing. In R v Morby (1882) 8 QBD 571 a father, due to his religious views, did not employ a doctor to treat his son, who later died of small pox. The medical evidence at trial had been that proper medical attention might have saved or prolonged the child's life, and would have increased his chance of recovery, but might have been of no avail. Following a conviction for manslaughter, the case was referred to the Queen's Bench Division, as a Crown Case Reserved. Quashing the conviction, Lord Coleridge CJ explained:

"It is not enough to show neglect of reasonable means for preserving or prolonging the child's life, but to convict of manslaughter it must be shown that the neglect had the effect of shortening life. The medical witness called for the prosecution gave his evidence clearly and well, and under a high sense of his duty and responsibility, and what he stated was, that in his opinion the chances of life would have been increased by having medical advice, that life might possibly have been prolonged thereby, or, indeed, might probably have been, but that he could not say that it would, or indeed that it would probably, have been prolonged thereby. In order to sustain the conviction affirmative proof is required."

28.

Similarly, in R v Sinclair (1998) WL 1044437, 21 August 1998 where breach was alleged to arise out of omission to act in a case where there has been evidence of a decreasing chance of survival as time passed, the court was concerned that there was no investigation as to the extent to which the expert was capable of excluding an acceleration of death that was no more than de minimis. In the course of his judgment, however, Rose LJ referred (at page 15) to the perception that the judge had of the evidence and his summary to living "appreciably longer" and to life being cut "appreciably shorter" without suggesting that there was any difference between the two.

29.
Although a coronial case, it is also worth referring to R(Khan) v West Hertfordshire Coroner [2002] EWHC 302 (Admin) because Richards J (as he then was) there seeks to illustrate that causation can be established without showing that the deceased would have survived. He went on (at [43(ii)]):

"But that is because it can be established by showing in the alternative that death, although inevitable, was hastened by the conduct in question. … the case [R(Dawson) v Coroner for East Riding and Kingston upon Hull [2001] EWHC 352 Admin] does not support the proposition that causation can be established simply by showing that there was an opportunity to render care. It must be shown to the requisite standard of proof that care would have been rendered and that it would have saved or prolonged life."

Thus, as with Rose LJ, Richards J uses the formulation "death, although inevitable, was hastened" synonymously with "care … would have saved or prolonged life".

30.
If the jury found that death occurred significantly sooner because Jack did not receive the necessary treatment, it is an inescapable corollary that proper treatment would have prolonged, that is to say, lengthened life. In our judgment, that is not in any way a different or alternative test: the two concepts are not inverse but merely different sides of the same coin.

31.
The second submission identified by Ms Johnson in relation to the direction on causation is that the judge should have explained to the jury what he meant by the phrase "significantly sooner": this was the point that Ms Johnson raised when the direction was discussed. She also argues that it was incumbent on the judge to direct the jury that it was not sufficient for the Crown to show that there was an opportunity lost which might have prolonged life.

32.
In our judgment, there is no point at which Nicol J limited his direction to lost opportunity. He was emphatic that the jury had to be sure "that Jack died significantly sooner" because of the negligence (by which it is clear he meant gross negligence) of the defendant whose case was being considered. As for an explanation of the phrase "significantly", the judge did explain that how big a contribution had to be in order to qualify as significant was left to the good sense of the jury, adding "although it must be more than trivial or minimal". We agree with the observation of Nicol J in argument that further definition would have been confusing and unnecessary. This is the same approach as that adopted by the Supreme Court in relation to the word "substantial" in the context of diminished responsibility: see R v Golds [2016] UKSC 61 at [42] and [43(1)].

33.
The third submission in relation to causation concerned the administration of enalapril. The judge said that the prosecution would have failed to prove its case if the effect of that drug was or may have

been so dominant that any acts or omissions of the defendants did not make a significant contribution to Jack dying as and when he did. Although he did not (and did not need to) spell this out, the converse must have been obvious: a defendant would only be guilty if her acts or omissions did make a significant contribution to Jack dying as and when he did. Far from being unhelpful, this direction correctly reflected the position and provided a good example which the jury could use to decide of what they were sure in relation to causation.

34.
A fourth submission, developed orally, was that the judge had failed to direct the jury that if "the point of no return" had been reached at any given time, later negligence could not be causative and that he had failed also to explain this direction by reference to the facts of the case, in particular the evidence of Dr Nadel that he could not be sure that this point had not been reached as early as 2.30 pm. However, in the light of the direction on this issue which we have set out above, this submission is untenable.

35.
Finally, although not the subject of elaboration in oral submissions, Ms Johnson expressed concern about the analogy which the judge provided of the unlawful shooting of a mortally wounded prisoner. This analogy was a useful example of how a new cause may supervene to extinguish the causative potency of what had gone before and also explains how the jury must concentrate on the death which occurred and not another death which might have occurred. It is not and was not intended to be a complete explanation of the law but its inclusion cannot be faulted; even if it not entirely apposite, its enunciation could not affect the safety of the conviction.

36.
In the circumstances, we reject the challenge to the way in which the jury were directed as to causation. A further ground (relating to the direction on gross negligence and, in particular, the state of mind of the Dr Bawa-Garba at the time of the act/omission) was not pursued. We raised with Ms Johnson whether the recent decision in R v Sellu [2016] EWCA Crim 1716 had affected the position but she rightly recognised that the judge had correctly directed the jury that the prosecution had to show that what a defendant did or didn't 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.

Conclusion

37.
In common with the single judge (who provided a masterly analysis of the case), although its importance both to Jack's family and to Dr Bawa-Garba has led us to consider the application in detail, we have come to the clear conclusion that none of the grounds of appeal are, in fact, arguable. In the circumstances, this renewed application for leave to appeal is refused.