Neutral Citation Number: [2018] EWHC 76 (Admin)

Case No: CO/3089/2017

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
DIVISIONAL COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 25 January 2018

Before :

LORD JUSTICE GROSS
MR JUSTICE OUSELEY

- -

Between :

GENERAL MEDICAL COUNCIL	**Appellant**
- and -	
DR BAWA-GARBA	**Respondent**

- -
- -

MR IVAN HARE QC
(instructed by **GENERAL MEDICAL COUNCIL LEGAL**) for the **Appellant**
MR SEAN LARKIN QC AND MR JULIAN WOODBRIDGE
(instructed by **RADCLIFFE LE BRASSEUR**) for the **Respondent**

Hearing date: 7 December 2017

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Judgment Approved

MR JUSTICE OUSELEY :

1. This is an appeal by the General Medical Council, the GMC, against the decision of the Medical Practitioners Tribunal, the Tribunal, on 13 June 2017 that Dr Bawa-Garba, whose fitness to practise had been found to be impaired, should in consequence be suspended from practice for one year. The GMC appeals on the ground that the Tribunal should have ordered that she be erased from the register. Dr Bawa-Garba had been convicted, on 4 November 2015 at Nottingham Crown Court before Nicol J and a jury, of manslaughter by gross negligence of a 6 year old boy. She was sentenced to two years imprisonment, suspended for two years.

2. On 29 November 2016, the Court of Appeal Criminal Division, refused her leave to appeal against her conviction. Sir Brian Leveson, President of the Queen's Bench Division, gave the judgment of the Court, in which he set out the issues at trial fully and I quote, gratefully, from it.

> "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 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.

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.
>
> 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."

4. Nurse Amaro was also convicted of manslaughter by gross negligence, received the same sentence, and in due course was removed from the Register of Nurses and Midwives. The Ward Sister was acquitted.

The Tribunal hearings

5. In February 2017, Dr. Bawa-Garba admitted the conviction and sentence, which was the allegation against her. The Tribunal which included a legally qualified member then had to decide whether on the basis of her conviction for that offence her fitness to practise was impaired. It heard oral evidence from two consultants, but not from Dr. Bawa-Garba. It concluded that her fitness to practise was impaired. In June 2017, the same Tribunal had to consider what sanction, if any, to impose. It heard further oral evidence, but not from Dr. Bawa-Garba. It imposed the sanction of 12 months suspension subject to review, but that review could not lead to an extension of the suspension. It rejected the GMC's contention that Dr. Bawa-Garba's name should be erased from the register as a disproportionate sanction.

The statutory framework

6. Sections 1 and 40A(1)(a)(i) of the Medical Act 1983, as amended, provide as follows:

"(1A) The over-arching objective of the General Medical Council in exercising their functions is the protection of the public.

(1B) The pursuit by the General Medical Council of their over-arching objective involves the pursuit of the following objectives –

(a) to protect, promote and maintain the health, safety and well-being of the public,

(b) to promote and maintain public confidence in the medical profession, and

(c) to promote and maintain proper professional standards and conduct for members of that profession.

40A – Appeals by General Council

This section applies to any of the following decisions by a Medical Practitioners Tribunal –

a decision under section 35D giving -

a direction for suspension, including a direction extending a period of suspension;….

(3) The General Council may appeal against a relevant decision to the relevant court if they consider that the decision is not sufficient (whether as to a finding or a penalty or both) for the protection of the public.

(4) Consideration of whether a decision is sufficient for the protection of the public involves consideration of whether it is sufficient –

(a) to protect the health, safety and well-being of the public;

(b) to maintain public confidence in the medical profession; and

(c) to maintain proper professional standards and conduct for members of that profession.

(6) On an appeal under this section, the court may –

(a) dismiss the appeal;

(b) allow the appeal;

(c) substitute for the relevant decision any other decision which could have been made by the Tribunal; or…."

7. The GMC (Fitness to Practise) Rules Order in Council 2004 provide in Rule 34 (3) and (5):

"(3) Production of a certificate purporting to be under the hand of a competent officer of a Court in the United Kingdom or overseas that a person has been convicted of a criminal offence or, in Scotland, an extract of conviction, shall be conclusive evidence of the offence committed…

(5) The only evidence which may be adduced by the practitioner in a rebuttal of a conviction or determination certified in a manner specified in paragraph (3) or (4) is evidence for the purposes of proving that he is not the person referred to in the certificate of extract."

8. The principles to be applied by the Court on appeals under s40A have been set out by Sharp LJ in *GMC v Jagjivan and PSA* [2017] EWHC 1247 (Admin), so far as material as follows at [40]:

"(i) Proceedings under section 40A of the 1983 Act are appeals and are governed by CPR Part 52. A court will allow an appeal under CPR Part 52.21(3) if it is 'wrong' or 'unjust because of a serious procedural or other irregularity in the proceedings in the lower court.

(ii) It is not appropriate to add any qualification to the test in CPR Part 52 that decisions are 'clearly wrong': see *Fatnani* at paragraph 21 and *Meadow* at paragraphs 125 to 128.

(v) In regulatory proceedings the appellate court will not have the professional expertise of the Tribunal of fact. As a consequence, the appellate court will approach Tribunal determinations about whether conduct is serious misconduct or impairs a person's fitness to practise, and what is necessary to maintain public confidence and proper standard in the profession and sanctions, with diffidence: see *Fatnani* at paragraph 16: and *Khan v General Pharmaceutical Council* [2016] UKSC 64; [2017] 1WLR, at paragraph 36.

(vi) However there may be matters, such as dishonesty or sexual misconduct, where the court "is likely to feel that it can assess what is needed to protect the public or maintain the reputation of the profession more easily for itself and thus attach less weight to the expertise of the Tribunal…": see *Council for the Regulation of Healthcare Professionals v GMC and Southall* [2005] EWHC 579 (Admin); [2005] Lloyd's Rep. Med 365 at paragraph 11, and *Khan* at paragraph 36(c). As Lord Millett observed in *Ghosh v GMC* [2001] UKPC 29; [2001] 1 WLR 1915 and 1923G, the appellate court "will afford an appropriate measure of respect of the judgment in the committee…but the [appellate court] will not defer to committee's judgment more than is warranted by the circumstances."

(vii) Matters of mitigation are likely to be of considerably less significance in regulatory proceedings than to a court imposing

retributive justice, because the overarching concern of the professional regulator is the protection of the public."

9. I need also to refer further to *Fatnani and Raschid v GMC* [2007] EWCA Civ 46; [2007] 1WLR 1460 at [17 -18] where Laws LJ said:

> "17. The first of these strands may be gleaned from the Privy Council decision in *Gupta v General Medical Council* [2002] 1 WLR 1691, para 21, in the judgment of their Lordships delivered by Lord Roger of Earlsferry:
>
> > "It has frequently been observed that, where professional discipline is at stake, the relevant committee is not concerned exclusively, or even primarily, with the punishment of the practitioner concerned. Their Lordships refer, for instance, to the judgment of Sir Thomas Bingham MR in *Bolton v Law Society* [1994] 1 WLR 512, 517 – 519 where his Lordship set out the general approach that has to be adopted. In particular he pointed out that, since the professional body is not primarily concerned with matters of punishment, considerations which would normally weigh in mitigation of punishment have less effect on the exercise of this kind of jurisdiction. And he observed that it can never be an objection to an order for suspension that the practitioner may be unable to re-establish his practice when the period has passed. That consequence may be deeply unfortunate for the individual concerned but it does not make the order for suspension wrong if it is otherwise right. Sir Thomas Bingham MR concluded, at p 519: 'The reputation of the profession is more important than the fortunes of any individual member. Membership of a profession brings many benefits, but that is part of the price.' Mutatis mutandis the same approach falls to be applied in considering the sanction of erasure imposed by the committee in this case.
> >
> > 18. The panel then is centrally concerned with the reputation or standing of the profession rather than the punishment of the doctor. This, it seems to me, engages the second strand to which I have referred."

10. This passage is important because it shows, contrary to a suggestion from Mr Larkin QC for Dr Bawa-Garba, that the comments of Sir Thomas Bingham MR in *Bolton* apply to doctors as much as to solicitors.

Sanctions Guidance

11. The Sanctions Guidance issued by the GMC identifies at [14] the tripartite statutory objective taken from s1 Medical Act, above. It says this of "Maintaining public confidence in the profession" at [17] and "Promoting and maintaining proper professional standards" at [19]:

> "17. Patients must be able to trust doctors with their lives and health, so doctors must make sure that their conduct justifies

> their patients' trust in them and the public's trust in the profession …. Although the Tribunal should make sure the sanction it imposes is appropriate and proportionate, the reputation of the profession as a whole is more important than the interests of any individual doctor.
>
> 19….Action is taken where a serious or persistent breach of the guidance has put patient safety at risk or undermined public confidence in doctors."

12. The Guidance points out [24] that mitigating factors carry less weight in relation to concerns about patient safety or of a more serious nature "than if the concern is about public confidence in the profession". Mitigating factors include: insight into the problem, remediation, adherence to good practice, past record, the circumstances leading to incidents of concern such as lack of training or supervision, personal and professional matters such as work-related stress and the lapse of time since an incident occurred, [25]. It says this of remediation, i.e. addressing concerns about for example a doctor's skill. Where remediation is fully successful, a finding of impairment is unlikely, [31]. But it continues:

> "32. However, there are some cases where a doctor's failings are irremediable. This is because they are so serious or persistent that, despite steps subsequently taken, action is needed to maintain public confidence. This might include where a doctor knew, or ought to have known, they were causing harm to patients, and should have taken steps earlier to prevent this."

13. Aggravating factors include, [47 – 48], lack of insight, which is likely where a doctor refuses to apologise or accept his or her mistakes.

14. Suspension is dealt with at [86]:

> "Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (i.e. for which erasure is more likely to be the appropriate sanction because the Tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession)."

15. Suspension may be appropriate for example where there has been an acknowledgment of fault and the behaviour is unlikely to be repeated or where there was deficient performance, but is evidence of insight and the potential for remediation; [87-88], or where there is no evidence of the repetition of similar behaviour since the incident; [91]. Factors showing that suspension may be appropriate are exemplified in [91].

16. The appropriateness of erasure is dealt with at [102-103 a, b, c] in these terms:

> "102. Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and

maintain high standards within the profession that is incompatible with continued registration as a doctor.

103. Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).

a) A particularly serious departure from the principles set out in *Good Medical Practice* where the behaviour is fundamentally incompatible with being a doctor.

b) A deliberate or reckless disregard for the principles set out in *Good Medical Practice* and/or patient safety.

c) Doing serious harm to others (patients or otherwise), either deliberately or through incompetence and particularly where there is a continuing risk to patients (see further guidance below at paragraphs 123 – 126 regarding failure to provide an acceptable level of treatment or care)."

Other examples include violence and dishonesty.

17. [123] and [126] state:

"Failing to provide an acceptable level of treatment or care

123. Cases in this category are those where a doctor has not acted in a patient's best interests and has failed to provide an adequate level of care, falling well below expected professional standards…. Particularly where there is a deliberate or reckless disregard for patient safety or a breach of fundamental duty of doctors to '*Make the care of [your] patients [your] first concern' (Good Medical Practice,* paragraph 1)."

"126. However, there are some cases where a doctor's failings are irremediable. This is because they are so serious or persistent that, despite steps subsequently taken, action is needed to maintain public confidence. This might include where a doctor knew, or ought to have known, they were causing harm to a patient and should have taken steps earlier to prevent this."

The Tribunal's Decisions: impairment

18. There was no dispute but that Dr Bawa-Garba's fitness to practise was impaired. The Tribunal found that she "fell below the standards expected of a competent doctor at your level" [18], had brought the profession into disrepute, and breached a fundamental tenet of the medical profession relating to good clinical care. Her clinical failings, serious as they were, had been remedied, leaving a low risk of future harm, [19]. It accepted a submission that her failings had come "out of the blue and for no apparent reason", the risk of her "suddenly and without explanation falling below the standards expected on any given day" were "no higher than for any other reasonably competent doctor." Although impairment was not at issue, the tone of these findings does not sit comfortably, in my judgment, with the number and severity of Dr Bawa-Garba's failings that day, nor the significance of the absence of any clear explanation as to why they happened. However, it is important for what follows that

the Tribunal concluded that a finding of impairment was required to maintain public confidence in the profession and to promote proper professional standards and conduct; [21-23].

The Tribunal's Decisions: Sanction

19. No complaint can be made of the approach of the Legal Assessor to the overarching objectives in the Medical Act, above. The Sanctions Guidance was properly noted. The Tribunal took account, [14], of its impairment finding, and rightly noted that sanctions were not to punish the doctor but were to be protective of patients and public confidence in the profession, [16]. At [18 - 19] mitigating and aggravating factors were set out as follows:

> "Mitigating Factors
>
> In mitigation the Tribunal had regard to the following factors:
>
> - Other than this matter, you have an unblemished record as a doctor
> - You were of good character prior to your offence
> - You remained employed by the Trust up until your conviction in 2015
> - There is no evidence of any concerns being raised regarding your clinical competency before or after your offence
> - The length of time which has passed since your offence
> - Before the events of 18 February 2011, you had recently returned from maternity leave and whilst you had completed come on-call shifts, this was your first shift in an acute setting
> - On the day in question, you were covering CAU, the emergency department and the ward
> - The multiple systemic failures identified in the Trust investigation following the events of 18 February 2011
> - There is no evidence to suggest that your actions on 18 February were deliberate or reckless.
>
> Aggravating Factors
>
> The Tribunal balanced those mitigating factors against what it considered to be the aggravating factors in this case:
>
> - Patient A was vulnerable by reason of his age and disability
> - Your failings in relation to Patient A were numerous, continued over a period of hours and included your failure to reassess Patient A following your initial diagnosis or seek assistance from senior consultants

- Even though you expressed your condolences to the family of Patient A, there is no evidence before this Tribunal that you subsequently apologised to them."

20. The decision swiftly and rightly rejected taking no action or imposing conditions on registration.

21. The Tribunal then considered suspension in [26 –29]:

> "26. The Tribunal was mindful that your actions marked a serious departure from Good Medical Practice, and contributed to Patient A's early death and which continues to cause great distress to Patient A's family.
>
> 27. It reminded itself of its findings in its determination on impairment, namely:
>
> - It was satisfied that you had remediated the deficiencies in your clinical skills and had practised safely for a period of almost 4 years; both Dr. Barry and Dr. Cusack described you as an excellent doctor.
>
> - It was satisfied that the risk of you putting a patient at unwarranted risk of harm in the future was low.
>
> - The basis of the Tribunal's finding on impairment was that public confidence in the profession and upholding of proper standards would be undermined if a finding of impairment were not made in your case.
>
> 28. The Tribunal had regard to the oral evidence of Dr. Cusack, who stated that following the events of 18 February 2011, a Trust investigation was carried out which highlighted multiple systemic failures which existed at the time of these events. These included failings on the part of the nurses and consultants, medical and nursing staff shortages, IT system failures which led to abnormal laboratory test results not being highlighted, the deficiencies in handover, accessibility of the data at the bedside, and the absence of a mechanism for an automatic consultant review. The Tribunal therefore determined that whilst your actions fell far short of the standards expected and were a causative factor in the early death of Patient A, they took place in the context of wider failings.
>
> 29. The Tribunal was satisfied that the evidence of Dr. Cusack was honest and reliable and that he could appropriately testify to your level of insight and remorse as he met with you regularly in a supervisory capacity…
>
> The Tribunal accepted the evidence of Dr. Cusack that you had reflected deeply and demonstrated significant and substantial insight in your conversations with him. However, the Tribunal was unable to conclude that you had complete insight into your actions as it did not hear from you directly."

22. The Tribunal then referred to *Bjil v GMC* [2001] UKPC 41,where the Privy Council, through Lord Hoffmann, said that the [FTP's] proper concern with public confidence in the profession and its procedures for dealing with "doctors who lapse from professional standards" 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."

23. The Tribunal concluded at [31 – 32]:

> "31. Further, the Tribunal was of the view that a fully informed and reasonable member of the public would view suspension as an appropriate sanction, given all the circumstances of your case. It was therefore satisfied that the goal of maintaining public confidence in the profession would satisfied by suspension of your registration.
>
> 32. The Tribunal also considered whether it would be appropriate to erase your name from the Medical Register. However, in the circumstances of the case, balancing the mitigating and aggravating factors, the Tribunal, concluded that erasure would be disproportionate. In reaching this decision, it considered paragraphs 101 – 105 and 126 of the Sanctions Guidance. In the judgment of the Tribunal, in all of the circumstances of this case, your actions and subsequent conviction are not fundamentally incompatible with continued registration. It also concluded that public confidence in the profession would not be undermined by a lesser sanction; your actions were neither deliberate not reckless. Although your actions resulted in the early death of Patient A, you do not present as a continuing risk to patients. The Tribunal did not consider that your failings are irremediable; indeed it has already found that you have remedied them."

24. Finally, the Tribunal directed a later review of the suspension order at a hearing.

The parties' submissions

25. It was not at issue but that if we were satisfied that the Tribunal was wrong in its decision on sanction, we should decide what the sanction should be; and that the decision could only be wrong if the sanction should have been erasure.

26. Mr Hare QC for the GMC submitted (i) that the Tribunal had in effect allowed evidence of systemic failings to undermine Dr. Bawa-Garba's personal culpability, and to do so even though those failings had been before the Crown Court which convicted her, and (ii) that remediation and personal mitigation were of too limited weight to satisfy the requirements of the public interest in upholding confidence in the profession.

27. As to (i), all the significant systemic factors or responsibility of others were before the jury, as could be seen by comparing the Decision on Sanctions at [28] with the judgment of the CACD at [17–18], and the summing up at p136. Two others were raised: automatic consultant review and the absence of bedside data; but these were of no consequence because Dr Bawa-Garba could have called on a consultant (summing up p125) and she had failed to use the data she had. The Decision at [28] showed the Tribunal's view that these systemic failings diminished, in its mind, the significance of what the jury must have concluded as to Dr Bawa-Garba's personal culpability in

convicting her. If she had become deskilled during her maternity leave, Decision [18], it was Dr. Bawa-Garba's responsibility, under *Good Medical Practice,* to "recognise and work within the limits of [her] competence"; and it was before the jury; summing up p42. The fact that her actions were not deliberate or reckless is not relevant to a conviction for manslaughter by gross negligence. Evidence of her good character and medical record went to the jury, as the summing up at p30 showed, as part of her rejected defence, and not just as post-conviction mitigation.

28. As to (ii) remediation: her remediation was accepted by the Tribunal; the Tribunal was properly advised on the principles relating to sanction; its findings on impairment were properly considered. However, much less weight should be given to remediation in considering sanction when the public interest had to be considered. The same applied to personal mitigation, applying the principles derived from *Jagjivan, Fatnani*, and *Gupta, above*. But Dr Bawa-Garba had limited insight by comparison with those who self-referred, admitted their fault, apologised, did not blame others or systems but instead accepted personal responsibility. Mr Hare denied that his submissions in reality were that erasure was the only proper sanction in any case of manslaughter by gross negligence, but there was a "presumption" in favour of such a sanction in the absence of exceptional circumstances, which did not exist here. Such circumstances could arise in a truly one-off case where the registrant showed truly exceptional insight and remediation such as where someone self-referred, apologised and fully recognised their failings and personal responsibility. Dr. Bawa-Garba was not a truly exceptional doctor.

29. Mr Larkin submitted that, as there was no rule or guidance that manslaughter by gross negligence necessarily led to erasure, the appropriateness of that sanction depended on all the facts of the case. The Tribunal had directed itself in line with the Sanctions Guidance and the specific factors of relevance, including whether the acts were deliberate or reckless. Dr. Bawa-Garba's acts were neither deliberate or reckless, but were honest errors. Nor were they, as Nicol J had said, the result of laziness or selfishness. The Tribunal had reached conclusions on the facts of remediation, mitigation and wider circumstances which were entirely open to it and should be respected.

30. It had considered the tripartite objectives and, in line with *Bijl*, deference or respect should be accorded to its evaluation of those issues. The Tribunal included two lay members well placed to consider public confidence and the maintenance of standards. Dr. Bawa-Garba had been a very good trainee, and neither before or after the events of that day had there been any cause for concern. Systemic failures had put her in a difficult position; there had never been any dispute about the admissibility of that evidence. They were relevant to mitigation and to explaining Dr. Bawa-Garba's errors. Indeed, the GMC's own submissions to the Tribunal accepted [Day 4/ p9E] that there had been failures by others.

31. One of the consultants who gave evidence on behalf of Dr. Bawa-Garba, at both the Impairment and Sanctions hearing was very critical indeed of what he saw as the lapses of another consultant; [Day 4 p37].

32. This was still relevant to the degree of fault to be attributed to Dr Bawa-Garba, within manslaughter by gross negligence, relevant to explaining the cause of her errors without being a defence to her crime.

33. Remediation and mitigation went primarily to patient safety but were also relevant to public confidence and sanction as the GMC accepted. She had returned after maternity leave, not realising how far she had become deskilled, and had been

deployed to the CAU unexpectedly, which had no control over admission numbers; the expected consultant was not in routine attendance, though another was on call; she had more supervision to do. Public confidence was not public opinion but it required a fair, impartial system operating in accordance with settled legal principles.

34. To the extent that the absence of apologies had been a concern in relation to insight, it was relevant that the CPS had initially decided to take no action, changing its mind only after the Coroner's Inquest. The GMC had eventually obtained an Interim Supervision Order which the High Court had discharged after a few months, and after she had been charged. Thereafter Dr. Bawa-Garba faced trial. She had in fact now apologised to the boy's family. The lapse of time had given her the opportunity to reflect on and address fully her errors, and to demonstrate her continuing competence. There had been no repetition of the errors, still less repetition after warning.

Conclusions

35. This is a sad and distressing case both for the parents of the six-year-old boy who died significantly sooner than he would otherwise have done, and for Dr. Bawa-Garba who, with an otherwise unblemished record, has had to come to terms, over a period of several years, with her very serious failings in his care. She has had to face trial, after being told that she would not be charged; she has been convicted of manslaughter by gross negligence, and given a two-year prison sentence, albeit suspended. I say that her failings caused the young patient to die "significantly sooner than he would otherwise have done" because that was the basis upon which Nicol J sentenced her, rather than on the alternative and more serious basis equally open to him on the jury's verdict, that Dr. Bawa-Garba's failures significantly contributed to his death.

36. I accept that the approach to adopt is that set out in *Jagjivan*, above: was the Tribunal decision wrong? I have to respect its findings of fact on which it heard evidence, and I should defer, in the legal sense, to its evaluation particularly in areas where its expertise exceeds that which Courts may have, respecting its specific functions and institutional experience.

37. Nonetheless, I have come firmly to the conclusion that the decision of the Tribunal on sanction was wrong, that the GMC appeal must be allowed, and that this Court must substitute the sanction of erasure for the sanction of suspension. No-one suggested that this issue should be remitted to the Tribunal for further consideration. I note what Nicol J said in sentencing Dr. Bawa-Garba, to the effect that the conviction meant that her career was over. It was an assumption or instinctive reaction to the circumstances before him, which may have mitigated sentence. But I have reached my own conclusion, unaffected by his reaction or expectation.

38. My reasons are set out below, but can be summarised in this way. Full respect had to be given by the Tribunal to the jury's verdict: that Dr. Bawa-Garba's failures that day were not simply honest errors or mere negligence, but were truly exceptionally bad. This is no mere emotive phrase as one witness, Dr. Barry, before the Tribunal appeared to suggest, [Day 2/93C], nor were her mistakes mere mistakes with terrible consequences. The degree of error, applying the legal test, was that her own failings were, in the circumstances, "truly exceptionally bad" failings. The crucial issue on sanction, in such a case, is whether any sanction short of erasure can maintain public confidence in the profession and maintain its proper professional standards and conduct. We consider that Mr Hare is right that the Tribunal's approach did not respect the true force of the jury's verdict nor did it give it the weight required when

considering the need to maintain public confidence in the profession and proper standards. I now set out my analysis more fully.

39. The Tribunal identified correctly the two central issues for its decision; I have set out what it said in its Sanctions Decision at [31]. It also referred to the relevant passages in the Sanctions Guidelines and constructed its analysis in a logical and conventional manner. I make this comment, however, on one of the cases to which it referred. Care is required with *Bijl v GMC* considered in [13] of the Decision. True and important it is that sanctions are protective not punitive. And it is right that the maintenance of public confidence and standards do not mean that "it is necessary to sacrifice the career of an otherwise competent and useful doctor who presents as no danger to the public in order to satisfy a demand for blame and punishment". That is simply saying that sanctions are not punitive and that the issue is not to be determined by expressions of opinion by the public. But it scarcely advances the decision whether one or another sanction is necessary for the two public interests at stake here. Nor is the decision any more advanced by public expressions of opinion by members of the medical profession on the same point. The relevant tests with cautionary words in relation to public confidence and the impact on a professional are now to be found in the cases cited above: *Jagjivan, Fatnami and Raschid* and *Bolton*. Those cases effectively supersede *Bijl,* which is an incomplete statement of the law now to be found in ss1 and 40A of the Medical Act, with the requirement to consider public confidence and maintenance of proper standards separately from patient safety.

40. I do not accept Mr Hare's submission that there is a presumption that a conviction for manslaughter by gross negligence should lead to erasure in the absence of exceptional or truly exceptional circumstances. That is not the test in the Sanctions Guidance in relation to any offence or acts meriting consideration of erasure, albeit that Mr Hare may be right that the rarity of convictions for manslaughter by gross negligence accounts for the absence of specific reference to it. Mr Larkin is right that the issue depends on the facts and circumstance of each case, considered individually – as to which the facts of other cases are of little value, including as here the decision of the Nursing and Midwifery Council that Nurse Amaro should be struck off, a decision reflecting her particular circumstances. Mr Hare referred to a plea of guilty, and an apology or a truly exceptional doctor as possible exceptional factors. They may be relevant. But as each case turns on its own facts it is unwise to circumscribe the factors required or alternatively of little weight.

41. However, the Decision on Sanctions, on a fair reading, shows 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, however, enjoined by R34 of the Rules, 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, in line with what the Rule states about Tribunal findings. Mr Larkin did not dispute that 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 CACD. Although Mr Larkin is right that such factors may reduce her culpability, they cannot reduce it below a level of personal culpability which was "truly exceptionally bad". 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. I cannot accept Mr Larkin's submission that that is in fact how the Tribunal approached its decision.

42. Paragraphs 18 and 28 of the Sanctions Decision specifically go through aspects of the systemic failings and the failings of others which were raised, albeit not always fully fleshed out, by Dr. Bawa-Garba in her defence, and not simply in mitigation after conviction. Although the Tribunal refers to them as "mitigation", that is by way of reducing the degree of her culpability. The language of paragraph [28] is quite striking in saying "…whilst your actions fell far short of the standards expected and were a causative factor in the early death of Patient A, they took place in the context of wider failings". I cannot read that other than as reducing her culpability in a way which the jury rejected. Its approach is not consistent with the verdict.

43. Although the Tribunal described the failings as "falling far short" of the standards expected, that does not mean that the Tribunal treated them as falling so far short of the standards expected as to be "truly exceptionally bad", as the jury found them to be, and so found notwithstanding the wider failings. Once the failings are found to be "truly exceptionally bad" personal failings by a jury, it is difficult to see how the systemic factors raised before it and rejected as adequate to reduce the seriousness of her failings, could play the significant role the Tribunal allowed them to play in mitigation of sanction, and indeed in its prior assessment of impairment, without the Tribunal contradicting the verdict. After all, they could not make her failings less than "truly exceptionally bad". Had the Tribunal adopted the correct approach, its reasoning would have been quite different, and differently expressed, and the outcome ought to have been different.

44. My conclusion is reinforced by the nature of the evidence given to the Tribunal on behalf of Dr. Bawa-Garba by Dr. Cusack and Dr. Barry to which no objection could be taken, focussing as it did on remediation and therefore on the nature and severity of the failings and the circumstances in which they occurred. There were views expressed which appeared at odds with the evidence accepted at trial, including over the obviousness of the diagnosis of sepsis. Cross-examination did focus on the severity of the failings implicit in the verdict, seemingly in an endeavour to point out that the doctors in substance and language were not acknowledging the gravity of the findings implicit in the jury's verdict. The upshot of the evidence and the language of the doctors however took the Tribunal away from how the severity of the failings for the purposes of sanction ought to have been judged.

45. There were two "systemic" failings not explored at trial which Mr Hare acknowledged, but we accept his submission that Dr. Bawa-Garba was convicted notwithstanding the difficulties to which they gave rise, and that they could not have affected the verdict.

46. Mr Larkin submitted that systemic failings also had this significance: failings which the systemic safety nets should have detected and removed on the day before any serious harm was done, were not working; so serious failings here had consequences which equally serious failings at another time simply would not have, and would not, perhaps, have led to any proceedings at all, let alone erasure. There is force in that point, but the personal responsibility of doctors for failings of the severity found by the jury here is not diminished by a failure in safety net, nor did the jury so conclude. They were the circumstances in which her failings occurred, but they did not cause them to occur, as the jury's verdict showed. The holes in the patient's safety net cannot reduce her personal culpability.

47. The factors of personal mitigation in [18], as opposed to systemic failings or the failings of others, also required consideration against their use at trial; pp41 – 42 of the summing-up referred to Dr. Cusack's evidence at trial of Dr Bawa-Garba's qualities. But they were deployed to assist her defence that, if failings there were by her, they did not fall so far below the standards to be expected of a reasonable doctor that they deserved to be characterised as severe, gross, or truly exceptionally bad. Again, it follows from the verdict, by which the Tribunal was bound, that the failings were indeed exactly that severe, notwithstanding those aspects of personal mitigation. Although that did not prevent their further deployment in mitigation of the offence at Court, nor in relation to impairment or sanction, the Tribunal's approach suffered from the same flaw as in relation to the role of systemic failings: it did not respect the jury's findings.

48. The impairment Decision concluded that a finding of impairment was necessary, not for reasons of patient safety, but because the conviction for manslaughter by gross negligence meant that public confidence in the profession would be undermined if no finding of impairment were made, and because a finding of impairment was required to promote and maintain proper professional standards. The Tribunal reminded itself of that finding when considering sanction, a finding it had reached although satisfied that Dr. Bawa-Garba's deficiencies in clinical skills had been successfully addressed or remediated, that she had practised safely for almost four years afterwards and the risk of her putting a patient at unwarranted risk and harm was low.

49. Where erasure is indicated, as on any view it was indicated here by the Sanctions Guidance at [103.c] - doing serious harm to a patient through incompetence even where there is no continuing risk to patients - a decision that erasure should not be imposed requires the reasons and circumstances why not, to be sufficiently significant to maintain public confidence in the profession and its professional standards. This was after all the basis for the finding of impairment, not a continuing need for remediation. The fact that she had already addressed her failings did affect her impairment which the sanction then had to address. I note in passing that [103.c] is not diminished by an absence of continuing risk, it is merely not made more emphatic; [32] of the Sanctions Decision, penultimate sentence, could be read as mistakenly discounting [103.c] of the Sanctions Guidance for that reason.

50. I accept the Tribunal conclusion on remediation, with its reservation about the completeness of insight in [29] of the Sanctions Decision, last sentence. I accept that there was personal mitigation, and that other things went wrong that day. However, where a patient dies sooner than he would have done because of a series of failings over the course of some hours for which the registrant has to take personal responsibility, and these are failings which the Tribunal had to treat as truly exceptionally bad, it would require rather stronger circumstances than those present for suspension to be sufficient to maintain public confidence in that profession, and its procedures for maintaining its professional standards.

51. Dr. Bawa-Garba, before and after the tragic events, was a competent, above average doctor. The day brought its unexpected workload, and strains and stresses caused by IT failings, consultant absences and her return from maternity leave. But there was no suggestion that her training in diagnosis of sepsis, or in testing potential diagnoses had been deficient, or that she was unaware of her obligations to assess for herself shortcomings or rustiness in her skills, and to seek assistance. There was no suggestion, unwelcome and stressful though the failings around her were, and with the workload she had that this was something she had not been trained to cope with or was something wholly out of the ordinary for a Year 6 trainee, not far off consultancy,

to have to cope with, without making such serious errors. It was her failings which were truly exceptionally bad.

52. Undoubtedly the fact that she has addressed the specific failings which arose suddenly and unexpectedly on that day, and that for many years afterwards she has practised safely and competently, is a factor which would weigh with "a fully informed and reasonable member of the public", a useful notion to invoke.

53. But I consider that the Tribunal did not give the weight required to the verdict of the jury, and was simply wrong to conclude that, in all the circumstances, public confidence in the profession and in its professional standards could be maintained by any sanction short of the erasure indicated by the Sanction Guidance at [103a and c]. This misconduct by manslaughter by gross negligence involved a particularly serious departure from the principles of "Good Medical Practice", and the behaviour was fundamentally incompatible with being a doctor. It involved truly exceptionally bad failings, causing very serious harm to a patient.

54. Accordingly, while recognising the impact on Dr. Bawa-Garba, I would allow the appeal and substitute the sanction of erasure for that of suspension.

LORD JUSTICE GROSS

55. I agree. Notwithstanding the system failures and the failures of others, the jury convicted Dr. Bawa-Garba of manslaughter by gross negligence. It necessarily follows that her failings on that day were "truly exceptionally bad". For the reasons given by Ouseley J, that reality was not properly reflected or respected in the Tribunal's Decision on Sanction and, on the facts of this case, drives me to the conclusion that the Tribunal was wrong and that the appropriate sanction must be erasure rather than suspension. Like Ouseley J, I reach this conclusion with sadness but no real hesitation.