C1/2018/0356

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE DIVISIONAL COURT
(Gross LJ and Ouseley J)
[2018] EWHC 76 (Admin)

BETWEEN:

DR HADIZA BAWA-GARBA

Appellant

-and-

GENERAL MEDICAL COUNCIL

Respondent

--and—

(1) BRITISH MEDICAL ASSOCIATION
(2) PROFESSIONAL STANDARDS AUTHORITY FOR HEALTH AND SOCIAL CARE

Interveners

RESPONDENT'S SKELETON ARGUMENT

Time estimate: the appeal has been listed for one and half days
Pre-reading: the Court is invited to read the Medical Practitioners Tribunals' determinations on Impairment and Sanction [76-87], the Judgment of the Divisional Court below [49-71] and the Parties Skeleton Arguments [13-47]
Time estimate for pre-reading: half a day
Numbers in square brackets correspond to page numbers in the Appeal Bundle; Tab numbers in the Authorities Bundle are indicated as: [Auth: XX]
References to paragraphs in the Divisional Court's judgment are in the form (DC: para no)

Introduction

1. The Respondent ("the GMC") files and serves this Skeleton argument in accordance with paragraph 4 of the Listing Window Notification Letter dated 13 April 2018.

2. Permission to appeal was granted on the papers by Simon LJ (sealed on 28 March 2018) [72-73].

3. The issue in the appeal is whether the Divisional Court was correct to quash the decision of the Medical Practitioners Tribunal ("MPT") to suspend the Appellant's ("Dr Bawa-Garba") registration for a period of 12 months after Dr Bawa-Garba had

been convicted of manslaughter by gross negligence, and to substitute instead the sanction of erasure from the medical register.

4. The Skeleton Argument falls into the following parts:

   (A) Relevant background;

   (B) Relevant law;

   (C) Dr Bawa-Garba's grounds of appeal; and

   (D) The GMC's response to the appeal.

(A) Relevant background

5. The MPT hearing in Dr Bawa-Garba's case began on 20 February and concluded on 12-13 June 2017. The allegation against Dr Bawa-Garba was admitted and was that:

   (1) on 4 November 2015 at Nottingham Crown Court, you were convicted of manslaughter on the grounds of gross negligence; and

   (2) on 14 December 2015, you were sentenced to 24 months' imprisonment suspended for 24 months.

6. The most authoritative account of the background to the MPT hearing appears in the summary of the facts provided by Sir Brian Leveson P in Dr Bawa-Garba's unsuccessful application for permission to appeal against her conviction (Hadiza Bawa-Garba v R [2016] EWCA Crim 1841) [151-161]:

   > 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 [Nurse Isabel Amaro and Ward Sister Theresa Taylor].*
>
> 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.*

7. In the Divisional Court, Ouseley J quotes further from the Court of Appeal's judgment (DC: 2).

8. The prosecution in the criminal case relied on a substantial number of failings by Dr Bawa-Garba which were said to have contributed to the death of Jack Adcock. They included:

    - Dr Bawa-Garba's initial and hasty assessment of Jack (at about 10.45-11am) after receiving the results of blood tests which ignored obvious clinical findings and symptoms; and

    - her subsequent consultations and the reassessment of Jack's condition, in particular, that she:

- did not properly review a chest x-ray taken at 12.01 pm which would have confirmed pneumonia much earlier;
- 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;
- failed to make proper clinical notes recording times of treatments and assessments;
- failed to ensure that Jack was given appropriate antibiotics timeously (more particularly, until four hours after the x-ray); and
- 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).

9. In his sentencing remarks at Nottingham Crown Court [176], Nicol J said:

> *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.*

10. In rejecting her application for permission to appeal, the Court of Appeal referred (at [36]) to the "truly exceptional degree of negligence which must be established" if gross negligence manslaughter is to be made out (R v Sellu [2016] EWCA Crim 1716 [Auth: 18]). The Court of Appeal found that Nicol J had directed the jury appropriately.

The MPT's decision

11. The MPT concluded that a finding of impairment was required to maintain public confidence and proper standards in the profession [79-80]. However, the MPT went on to impose a 12-month suspension (with a review) as sanction. In rejecting erasure, the MPT had regard to the following mitigating factors (at para 18 [83]):

- *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 some on-call shifts, this was your first shift in an acute setting*
- *On the day in question, you were covering the 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 2011 were deliberate or reckless.*

12. The MPT expanded on the failures at the hospital at para 28 [84-85]:

> *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.*

13. The MPT concluded at para 32 [85]:

> *. . . that public confidence in the profession would not be undermined by a lesser sanction; your actions were neither deliberate nor reckless. Although your actions resulted in the early death of Patient A, you do not present 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.*

<u>The GMC's appeal to the Divisional Court</u>

14. The GMC appealed to the Administrative Court under s. 40A of the Medical Act 1983 ("the 1983 Act") on the ground that the sanction of suspension was insufficient to protect the public as defined in s. 40A(3)-(4) of the 1983 Act [88-116]. The Divisional Court allowed the GMC's appeal and substituted the sanction of erasure.

(B) Relevant law

15. Section 1 of the 1983 Act provides (as relevant) [Auth: 1]:

> *(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.*

16. Section 40A of the 1983 Act provides (as relevant):

> *(1) This section applies to any of the following decisions by a Medical Practitioners Tribunal—*
> > *(a) a decision under section 35D giving—*
> > > *(i) a direction for suspension, including a direction extending a period of suspension;*
> >
> > . . .
>
> *(2) A decision to which this section applies is referred to below as a "relevant decision".*
>
> *(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 and quash the relevant decision;*
> > *(c) substitute for the relevant decision any other decision which could have been made by the Tribunal; or*
> > *(d) remit the case to the MPTS for them to arrange for a Medical Practitioners Tribunal to dispose of the case in accordance with the directions of the court,*
>
> *and may make such order as to costs . . . as it thinks fit.*

17. Rule 34(3) & (5) of the General Medical Council (Fitness to Practise) Rules Order of Council 2004 ("2004 Rules") [Auth: 2] provide:

> *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 conviction, shall be conclusive evidence of the offence committed.*
>
> *. . .*
>
> *The only evidence which may be adduced by the practitioner in rebuttal of a conviction or determination certified in the 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 or extract.*

18. The correct approach on appeals under s. 40A was laid down been a by a different Divisional Court in General Medical Council v Jagjivan & Anor [2017] EWHC 1247 (Admin); [2017] 1 WLR 4438 [Auth: 19], at [39-40]:

> *As a preliminary matter, the GMC invites us to adopt the approach adopted to appeals under section 40 of the 1983 Act, to appeals under section 40A of the 1983 Act, and we consider it is right to do so. It follows that the well-settled principles developed in relation to section 40 appeals (in cases including: Meadow v General Medical Council [2006] EWCA Civ 1390; [2007] QB 462; Fatnani and Raschid v General Medical Council [2007] EWCA Civ 46; [2007] 1 WLR 1460; and Southall v General Medical Council [2010] EWCA Civ 407; [2010] 2 FLR 1550) as appropriately modified, can be applied to section 40A appeals.*
>
> *In summary:*
>
>> *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.*
>>
>> *iii) The court will correct material errors of fact and of law: see Fatnani at paragraph 20. Any appeal court must however be extremely cautious about upsetting a conclusion of primary fact, particularly where the findings depend upon the assessment of the credibility of the witnesses, who the Tribunal, unlike the appellate court, has had the advantage of seeing and hearing (see Assicurazioni Generali SpA v Arab Insurance Group (Practice Note) [2002] EWCA Civ 1642; [2003] 1 WLR 577, at paragraphs 15 to 17, cited with approval in Datec Electronics Holdings Ltd v United Parcels Service Ltd [2007] UKHL 23, [2007] 1 WLR 1325 at paragraph 46, and Southall at paragraph 47).*

iv) When the question is what inferences are to be drawn from specific facts, an appellate court is under less of a disadvantage. The court may draw any inferences of fact which it considers are justified on the evidence: see CPR Part 52.11(4).

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 standards in the profession and sanctions, with diffidence: see <u>*Fatnani*</u> *at paragraph 16; and* <u>*Khan v General Pharmaceutical Council*</u> *[2016] UKSC 64; [2017] 1 WLR 169, 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 <u>*Council for the Regulation of Healthcare Professionals v GMC and Southall*</u> *[2005] EWHC 579 (Admin); [2005] Lloyd's Rep. Med 365 at paragraph 11, and* <u>*Khan*</u> *at paragraph 36(c). As Lord Millett observed in* <u>*Ghosh v GMC*</u> *[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 the 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.

viii) A failure to provide adequate reasons may constitute a serious procedural irregularity which renders the Tribunal's decision unjust (see <u>*Southall*</u> *at paragraphs 55 to 56).*

19. The Divisional Court in the present case set out (DC: 8) and applied (DC: 36) the guidance in <u>Jagjivan</u> in the present case.

(C) Dr Bawa-Garba's grounds of appeal

20. Dr Bawa-Garba advances five grounds of appeal, that the Divisional Court:

    (i) erred in applying a presumption that a conviction for manslaughter by gross negligence should lead to erasure in the absence of exceptional circumstances;

(ii) erred in failing to appreciate the distinct roles of the jury and the MPT;

(iii) erred in substituting its judgment for that of the MPT;

(iv) erred in concluding that, in taking account of the systemic failings at Leicester Royal Infirmary, the MPT failed to pay sufficient respect to the jury's decision; and

(v) reached an irrational conclusion.

(D) The GMC's response

21. The simple response to Dr Bawa-Garba's appeal is that the Divisional Court was correct to decide that the MPT failed to apply Rule 34 of the 2004 Rules and undermined the rationale for making criminal convictions conclusive evidence of the offence committed in disciplinary cases. This was because, as the Divisional Court held, the MPT relied on precisely the same mitigating evidence that the jury held did not reduce Dr Bawa-Garba's individual culpability below the level of "truly exceptionally bad" incompetence to hold that erasure was not required. That should be an end to the matter.

22. The GMC, however, addresses the individual grounds of appeal below.

(i) <u>Presumption of erasure</u>

23. This ground depends on Dr Bawa-Garba establishing that the Divisional Court did precisely what it said it was not doing. The Divisional Court rejected a presumption of erasure (DC: 40) and accepted that all the circumstances of the individual case should be considered.

24. In any event, this ground of appeal may be little more than exercise in semantics. The GMC accepted below and still accepts that a conviction for manslaughter by gross negligence does not automatically lead to erasure. On the other hand, Dr Bawa-Garba did not seek to appeal (as she could have done as of right under s. 40 of the 1983 Act) against the sanction of suspension. Presumably therefore, Dr Bawa-Garba accepts that it was open to the MPT to start from the position that taking no

action or imposing conditions on her registration would not be sufficient to mark the gravity of her conduct.

25. Dr Bawa-Garba does not challenge the Sanctions Guidance (2016) [Auth: 24] which makes clear (at para 102) that erasure may be appropriate (even where there is no risk to patient safety) in cases involving any one of: (a) "a particularly serious departure" from Good Medical Practice [Auth: 23] where the conduct is incompatible with being a doctor or (c) "doing serious harm to others … through incompetence". This is not expressed as a "presumption", but the advice contained in the Sanctions Guidance has been described as "an authoritative steer . . . as to the application of th[e] principle" of proportionality in particular, and, more generally, "as to what is required to protect the public". Departure from the steer provided by the Sanctions Guidance may be legitimate, but "requires careful and substantial case-specific justification" (General Medical Council v Khetyar [2018] EWHC 813 (Admin) [Auth: 22], at [22], per Andrew Baker J). In this context, the difference between an "authoritative steer" and a presumption may not be very great.

26. The crucial question is whether the Divisional Court properly took account of the individual circumstances of Dr Bawa-Garba's conduct (which included the defence she ran in her criminal trial and which the jury rejected). The Divisional Court cited the relevant parts of the Sanctions Guidance (DC: 16, 49 & 53) and concluded that the individual circumstances of Dr Bawa-Garba's case were not such that sufficiently significant reasons could be given to justify a sanction less than erasure whilst still maintaining public confidence in the profession and its professional standards in a case such as the present where a doctor had hastened a patient's death through "truly exceptionally bad"failings. The individual circumstances also included Dr Bawa-Garba's serious and repeated errors (as described by the Court of Appeal (Criminal Division) and quoted (DC: 2)). The Divisional Court therefore plainly had regard to the individual circumstances of the case.

27. There was no requirement on the Court to set out the exceptional factors that might make erasure disproportionate. As the Court stated, it did not wish to "circumscribe" the relevant factors (DC: 40).

(ii)/(iv) The role of the court and MPT

28. The Divisional Court's reasoning is straightforward and correct. The rules of evidence governing MPT hearings make a certificate of conviction conclusive evidence not just of the fact of conviction, but of the basis for the conviction (DC: 7). In the present case, the jury found Dr Bawa-Garba's failures to be "truly exceptionally bad". It was not open to the MPT to decide that the context in which Dr Bawa-Garba's conduct took place and the failings of others reduced her personal culpability below that level of "truly exceptionally bad". The Divisional Court was not reading anything into the MPT's findings: the MPT included "multiple systemic failings" in its list of mitigating factors and stated that it took account of Dr Bawa-Garba's failings "in the context of wider failings" (DC: 19 and 42). That can only mean that the MPT regarded those failings as reducing Dr Bawa-Garba's personal culpability.

(iii) Substituting judgment

29. This was a case where the MPT had imposed the second most severe sanction at its disposal (12 months' suspension). If the Divisional Court considered that to be wrong in the sense of not being sufficient to protect the public (the test under the 1983 Act), the only outcome was erasure. The parties below agreed this and did not seek to have the case remitted (DC: 37). This was not a case where the MPT had any advantage over the Divisional Court in assessing Dr Bawa-Garba's culpability because she decided not to give any evidence before the MPT. Similarly, the MPT had no advantage over the Divisional Court in terms of medical expertise because the standard of the Dr Bawa-Garba's care had already been found to be "truly exceptionally bad" by the jury.

30. The Divisional Court did not simply decide that the jury's verdict should have been given greater weight as one factor in a multi-factorial balance. The 2004 Rules required the conviction to be treated as conclusive evidence that Dr Bawa-Garba's individual culpability was "truly exceptionally bad". The MPT undermined the 2004 Rules and the jury's verdict by reaching its own conclusion on Dr Bawa-Garba's individual culpability by reference to systemic failings and the failings of others.

(v) Irrationality

31. The Divisional Court had regard to all the evidence before the MPT about Dr Bawa-Garba's career. The description of Dr Bawa-Garba's practice after the death of Patient A as being that she "practised safely as a doctor for almost four years" does not appropriately reflect the fact that she was on maternity leave for over a year in this period (January 2012-February 2013) and for a further 11 months (from December 2014 until her conviction) she was working in education with no patient contact at all. In any event, all these matters were emphasised by leading Counsel on behalf of Dr Bawa Garba before the Divisional Court.

Conclusion

32. For the above reasons, the GMC invites the Court to dismiss the appeal.

27 June 2018

IVAN HARE QC
Blackstone Chambers

C1/2018/0356

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RESPONDENT'S SKELETON ARGUMENT

GMC Legal
General Medical Council
3 Hardman Street
Manchester
M3 3AW

Tel: 0161-923 6602
Fax: 0161-923 6201

Ref: MS/Lit/BAWA-GARBA

Solicitors for the Respondent