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

SUBMISSIONS ON BEHALF OF THE SECOND INTERVENER, THE PROFESSIONAL STANDARDS AUTHORITY FOR HEALTH AND SOCIAL CARE

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29 June 2018.

Numbers in square brackets correspond to page numbers in the Appeal Bundle.

Tab numbers in the Authorities Bundle are indicated as: [Auth/ X].

Introduction

1. The Professional Standards Authority for Health and Social Care ("the Authority") was granted permission to intervene by order of Singh LJ on 8 May 2018 [149].

2. The Authority does not seek to support either party in the appeal. However, since points of wider public importance are to be ventilated, and the Court's decision has the potential to bear on the regulation of health and social care professionals beyond the circumstances of this case, the Authority seeks to fulfil its statutory obligations set out below by intervening in this case to assist the Court.

The Authority

3. The Authority is the statutory body charged by Parliament with promoting the interests of patients and other members of the public in relation to the performance of the functions of professional regulatory bodies in the sphere of health and social care, and formulating principles relating to good professional self-regulation (s.25 of the NHS Reform and Healthcare Professions Act 2002) ("the 2002 Act"). It was created as a result of the recommendation of the Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984-1995 (July 2001), Cm.5207.

4. Pursuant to the 2002 Act, the Authority's functions are:

   (a) to promote the interests of users of health care, users of social care in England, users of social work services in England and other members of the public in relation to the performance of their functions by the various healthcare regulatory bodies (including the Respondent) and by their committees and officers;

   (b) to promote best practice in the performance of those functions;

   (c) to formulate principles relating to good professional self-regulation, and to encourage regulatory bodies (including the Respondent) to conform to them; and

   (d) to promote co-operation between regulatory bodies, and between them, or any of them, and other bodies performing corresponding functions.

5. The overarching objective of the Authority in exercising its functions set out above is the protection of the public. Pursuit of that overriding-objective by the Authority includes pursuit of the following objectives:

    (a) to protect, promote and maintain the health, safety and wellbeing of the public;

    (b) to promote and maintain public confidence in the professions regulated by the regulatory bodies;

    (c) to promote and maintain proper professional standards and conduct for members of those professions.

6. For the purposes of assisting the Authority in its performance of its functions, the Authority may provide advice or auditing services to regulatory bodies (including the Respondent) and each regulatory body must, in the exercise of its functions, co-operate with the Authority.

7. The Authority has a broad power to do anything which appears to it necessary or expedient for the purpose of, or in connection with, the performance of its functions. Including, by way of the examples listed in the 2002 Act, to investigate, and report on, the performance by each regulatory body of its functions and to recommend to a regulatory body changes to the way in which it performs any of its functions.

8. The Authority is obliged to comply with a request by the Secretary of State, the Welsh Ministers, the Scottish Ministers or the relevant Northern Ireland department, for advice on any matter connected with a profession where it appears to the person making the request to be a health care profession.

9. A key power of the Authority arises in the context of its function of oversight of regulatory bodies' fitness to practise decisions. S.29 of the 2002 Act permits the Authority to refer relevant decisions of committees of the regulatory bodies to the

High Court, where the Authority considers a relevant decision is not sufficient (whether as to a finding or a penalty or both) for the protection of the public. Consideration of whether a decision is sufficient for the protection of the public involves consideration of whether it is sufficient to protect the health, safety and well-being of the public, to maintain public confidence in the profession concerned, and to maintain proper professional standards and conduct for members of that profession. On referral to the High Court, which is to be treated as an appeal, the Authority may ask the Court to allow that appeal and quash the relevant decision, substitute the relevant decision, or remit the case for reconsideration in accordance with directions.

10. In relation to the Respondent, the Authority may consider the sufficiency for the protection of the public of a direction of the Medical Practitioners Tribunal ("MPT") of the Respondent that the fitness to practise of a medical professional was (or was not) impaired, or of a direction for suspension of a person's registration or for conditional registration.

11. By section 40A of the Medical Act 1983 ("the 1983 Act"), the Respondent now has a corresponding power to consider relevant decisions by the MPT and appeal those decisions to the High Court. It was pursuant to s.40A which the matter now under appeal was lodged before the High Court and heard on 7 December 2017.

12. In such a case of an appeal brought by the Respondent pursuant to its powers under s.40A, the Registrar is required to give notice to the Authority of that appeal being lodged. Receipt of such notice precludes the Authority from itself referring the case to the High Court under s.29 of the 2002 Act; however, the Authority may, by service of notice and without permission, become a party to the appeal under s.40B of the 1983 Act.

13. Having become a party to such an appeal, the Authority is permitted to file evidence, make representations and raise any matter which it could have raised were it to have itself referred the case under s.29 of the 2002 Act. Where the Respondent withdraws an appeal pursuant to s.40A of the 1983 Act, the Authority

may also continue those proceedings, which would in that case be treated as a reference under s.29 of the 2002 Act.

14. In the instant matter, the Authority chose not to give notice pursuant to s.40B of the 1983 Act and did not therefore join the appeal, but given its statutory powers of scrutiny and oversight, explained above, the Authority has followed this case leading to the Appeal carefully.

15. In fulfilment of its statutory functions, the Authority reviews all the disciplinary decisions of all the health and social care regulatory bodies, as well as working with them to develop their regulatory schemes. It therefore has a unique breadth of experience in relation to the issues which arise in disciplinary and regulatory cases concerning health and social care professionals. This aspect of its role promotes consistency across the field of the discipline of health and social care professionals (paragraph 11.14, *Gross Negligence Manslaughter in Healthcare,* June 2018 ("the Review")). Given its insight from applying the same considerations and statutory test as the Respondent in its original referral of the case to the High Court, and for the wider reasons set out above in relation to its statutory functions, the Authority makes the following submissions in an effort to assist the Court to resolve the issues in dispute.

The importance of upholding public confidence in health and social care professionals

16. The fundamental importance of the reputation of a profession has long been acknowledged by the Court when considering professional disciplinary cases (*Bolton v The Law Society* [1994] 1 WLR 512, Sir Thomas Bingham, [Auth/4] at 518H).

17. There are powerful public policy reasons for positive measures to be taken to uphold public confidence in the health and social care professions, in particular.

18. Each of the statutory schemes devised for the discipline of health and social care professionals requires its disciplinary tribunal to have regard to the public interest in making decisions concerning individual clinicians, including upholding public confidence in the profession (for example, s.5 Health and Social Care (Safety and Quality) Act 2015, s.1(1ZB) Dentists Act 1984, a.3(4A) Nursing and Midwifery Order 2001). Similar considerations as to the sufficiency of a measure to maintain public confidence in the profession are to be addressed by the Authority when considering whether or not to refer a decision to the Court (paragraph 9 above).

19. As set out above (paragraph 5), one of the wider objectives of the Authority is the maintenance of public confidence in the health and social care professions, and that is intended by Parliament to be pursued by the Authority in the interests of the public, rather than the profession.

20. Thus, decisions at every stage of the legal process about whether a professional should continue to practise involve consideration of the impact on public confidence. It is also clear that the taking of decisions as to what is required in order to maintain public confidence in a profession is not, in the view of Parliament, solely an exercise for individual professional disciplinary bodies. The upholding of public confidence in the professional is a factor which must be considered independently by the Authority and the Court.

21. Recently, the Review found that "among professionals there is little understanding of what actions by a healthcare professional might lead to the public losing confidence in the profession" (page 42). This finding might be said to undermine the assertion that a disciplinary body is uniquely well-placed to determine what is required by way of disciplinary measures in order to uphold public confidence. However, it might also be said that no individual or body is able to state with confidence what individual actions or professional disciplinary responses to them would lead to the public losing confidence in the profession.

22. Certainly an issue of public confidence arises when considering whether a doctor convicted of the gross negligence manslaughter of a child patient should continue to practise. One need only ask the question - might an ordinary member of the public reasonably have pause when confronted with a situation in which a doctor who had been so convicted was to be responsible for the care and treatment of their child? Once that situation has been imagined, it is easy to see too the risk of a parent in such a position lacking confidence in the advice given by the doctor and being reluctant to adhere to it, or delaying in treatment whilst a second opinion is sought. And once it is understood how confidence in an individual clinician might thus be undermined then it is easy to see how a profession's failure properly to maintain standards might tend to reduce public confidence in it as a whole with the consequences outlined above.

23. However, whilst these concerns may be material to a professional disciplinary body's deliberations, the Authority wishes to emphasise two other factors so that they are properly seen in context. The first is that individual immediate or instinctive reactions to the fact that a clinician has been convicted of gross negligence manslaughter is not the best or only guide to the wider concept of public confidence in a profession. It should be borne in mind that there may be circumstances in which members of the public strongly deprecate the acts of one clinician and his subsequent disciplinary treatment, without there being a resulting real risk to public confidence in the profession as a whole. Moreover, the views of a vocal group of members of the public or the taking up by the media of the case of one individual clinician are not necessarily good indicators of public confidence in the profession as a whole.

24. The second factor is that the maintenance of public confidence in the profession is not the only respect in which the public interest is engaged in decisions about whether a clinician should continue to practise. So, whilst the maintenance of public confidence in the profession is a factor that ought to be taken into account, it should not be seen as the only public interest factor, determinative of the question of whether a clinician should continue to practise, nor disproportionately weighted as against other public interest factors.

The "diffidence" to be shown by the Court in respect of decisions of professional disciplinary tribunals which are the subject of appeals

25. It is common ground that the extent of the "diffidence" to be shown by the Court in a professional disciplinary case depends on the circumstances. For example, a case concerned with purely clinical issues, rather than those of moral conduct, will lead a Court to tend towards greater "diffidence". It is submitted on behalf of the Authority that the degree of diffidence to be shown may be less clear cut where a key issue is whether the steps taken by a professional disciplinary body in relation to a professional found guilty of a serious offence arising out of professional failings are those that are required to ensure the maintenance of public confidence in the profession. In such circumstances there are interlocking issues requiring both insight into clinical issues and the exercise of judgment in respect of public attitudes.

26. Whilst it is usually accepted that a professional disciplinary tribunal is in a more informed position when assessing the significance of clinical failings, it is also relevant to the extent of diffidence to be shown to such a tribunal that (as here) it has lay members amongst the decision-makers. They provide an important perspective, from outside the profession, informing the tribunal's collective judgments as to what public confidence in the profession might require by way of sanction in an individual case in order that such confidence be maintained.

The significance of a conviction for gross negligence manslaughter for a professional disciplinary tribunal's decision as to whether a health or social care professional should practise in the future

27. The core submission of the Authority under this heading is that the decisions of the Crown Court and MPT (or any professional disciplinary tribunal) are taken by different bodies with different functions, addressing different questions and at different times.

28. It cannot be disputed that the decision of a jury that a professional is guilty of gross negligence manslaughter should itself be afforded proper respect by a professional disciplinary tribunal. However, that decision is far from determinative of the wider range of issues that the tribunal must consider, including what insight is displayed by the clinician and the extent to which he has remediated the failings which were relied upon to prove the offence of which he was convicted by the jury.

29. It may also be important to bear in mind that once the function within society of the finding of guilt by a jury has been fulfilled, there is no need for that role to be duplicated by the tribunal. The issues to be addressed by tribunal are different, as well as wider and forward-looking.

30. Further, within the context of professional discipline, it may be unhelpfully distracting to concentrate unduly on the fact of a conviction for gross negligence as a strong indicator of the appropriate professional disciplinary sanction. This is because not every serious clinical failing that causes a patient's death will result in criminal proceedings (e.g. if the CPS decides that it is not in the public interest to prosecute), and if there are such proceedings, their outcome may be influenced by a range of factors which are not directly relevant to professional discipline concerns. Moreover, there are often very serious clinical failings that do not result in death, so that there is no prosecution.

31. Following on from this point, the Authority considers that the instant is in many respects an unusual case. The Court should therefore be cautious in relying upon it to develop any particular principle of wider application.

The approach of professional disciplinary tribunals to individual clinical failings as against personal failings

32. The Authority would wish to remind the Court of the importance of professional insight and efforts at remediation when a professional disciplinary tribunal is

considering the appropriate sanction (for example, *GMC's Sanctions Guidance (2016)* [Auth/24] at paras 41 to 48). The weight to be attached to these factors is often reflected in guidance to tribunals that indicates that it is deep-seated attitudinal problems which are typically a good reason for deciding that a clinician should be prevented from practising. Whilst these attitudinal or character issues may arise in the circumstances of clinical failings, for example where there is a refusal to accept that there is any deficiency or to address it, they are still character rather than clinical issues which render the professional one who cannot properly be allowed to practise.

33. The Authority submits that this is another good reason why the Court should hesitate before endorsing an approach which supports effectively a degree of automaticity in finding that a past error on the part of a clinician is fundamentally incompatible with continued registration without full consideration of any insight into and remediation of that error, particularly where the index error is a matter of clinical practice rather than character.

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29 June 2018