Appeal No.C1/2018/0356

IN THE COURT OF APPEAL

CIVIL DIVISION

ON APPEAL FROM THE DIVISIONAL COURT (GROSS LJ AND OUSELEY J)

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

APPELLANT'S PERFECTED SKELETON ARGUMENT

References: **[CB/x]** are to page numbers in the core bundle

[SB/x] are to page numbers in the supplemental bundle

[DC/x] are to paragraphs in the judgment of the Divisional Court **[CB/49-71]**

[I/x] are to paragraphs in the MPT determination on impairment **[CB/76-80]**

[S/x] are to paragraphs in the MPT determination on sanction **[CB/81-86]**

[Auth/x] are to tabs in the agreed bundle of authorities

I. INTRODUCTION

Issue

1. Whether the Divisional Court erred in law by substituting the sanction of erasure from the medical register for the sanction of suspension ordered by the Medical Practitioners Tribunal (**"the MPT"**).

Overview

2. On 20 February 2017 the MPT determined the Appellant's fitness to practise (**"FPT"**) to be impaired by reason of her conviction for the gross negligence manslaughter of Patient A on 4 November 2015 (**"the Impairment Determination"**) **[CB/76-80]**. Following a further hearing on 12 and 13 June 2017, the MPT suspended the Appellant from the medical register for a period of 12 months, and directed that a review of the suspension take place prior to its expiry (**"the Sanction Determination"**) **[CB/81-86]**. The MPT ordered the Appellant's suspension to take effect immediately **[CB/87]**.

3. On 25 January 2018, following an appeal by the Respondent, the General Medical Council (**"the GMC"**), pursuant to section 40A of the Medical Act 1983 (**"the 1983 Act"**) **[Auth/1]**, the Divisional Court substituted the sanction of erasure for that of suspension (see judgment at **[CB/49-71]** and order at **[CB/48]**). The Appellant appeals the Divisional Court's order.

4. Simon LJ granted permission to appeal on 28 March 2018 **[CB/72-73]**. On 8 May 2018 Singh LJ granted permission to the two interveners to intervene [**CB/149-150**].

Grounds of appeal

5. The Appellant advances five, interconnected, grounds of appeal **[CB/10-12]**:
   (i) The Divisional Court erred in applying a presumption that a conviction for gross negligence manslaughter should lead to erasure from the medical register save for in exceptional circumstances (**"ground one"**);
   (ii) The Divisional Court erred by failing to appreciate the distinct roles of the jury on the one hand, and the role of the MPT on the other (**"ground two"**);

(iii) The Divisional Court erred in substituting its own judgment for the judgment of the MPT (**"ground three"**);

(iv) The Divisional Court erred in concluding that the MPT was precluded from taking into account the evidence of systemic failures occurring in the Leicester Royal Infirmary (**"the Hospital"**) on 18 February 2011, as to do so would constitute a lack of respect for the jury's decision (**"ground four"**);

(v) In all the circumstances of this case, the Divisional Court's decision was irrational (**"ground five"**).

The wider public importance of the Appellant's appeal

6. As well as being of conspicuous personal importance to the Appellant, the appeal raises issues in the wider public interest (acknowledged by Singh LJ when granting the interveners permission to intervene). In particular:

(i) this appeal is the first appeal to the Court of Appeal concerning the GMC's right of appeal from a decision of the MPT contained in section 40A of the 1983 Act;[1]

(ii) the appeal raises important issues as to how the MPT should approach a sanction imposed to promote and maintain public confidence in the medical profession/proper professional standards and conduct for members of the profession where the registrant poses no risk of harm to patients;

(iii) the appeal raises important issues about the proper approach to the treatment of convictions for gross negligence manslaughter in the context of FTP, there being no such previous case to have reached the Court of Appeal.

7. Further, the erasure of the Appellant from the medical register pursuant to the Divisional Court's decision has caused very substantial consternation, verging on outrage, in the medical profession both in the United Kingdom and abroad. It has led to the Secretary of State for Health and Social Care to criticise the GMC in Parliament and to announce a formal review into various issues arising from this case. The

[1] We acknowledge that this point may have diminished in importance since the Secretary of State for Health announced on 11 June 2018 that the Government would support the recommendation of the Williams Review, including the recommendation that the GMC should lose its right to appeal against decisions of the MPT.

political sensitivity of this case could not be more acute. This provides an additional basis for its consideration by the Court of Appeal.

II. LEGAL FRAMEWORK

The statutory provisions

Overview

8. Section 1(1A) of the 1983 Act provides that the over-arching objective of the GMC in exercising its functions is the protection of the public **[Auth/1]**. By subsection (1B), the pursuit by the GMC of its 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.

9. By subsection (3) the GMC shall have committees that include the Medical Practitioners Tribunal Service. Pursuant to the Schedule to the General Medical Council (Constitution of Panels, Tribunals, and Investigation Committee) Rules Order of Council 2015 **[Auth/3]** a MPT must be comprised of at least three panellists, one of whom must be a medical member and one of whom must be a lay member.

Fitness to practise

10. Part V of the 1983 Act provides for "*FTP and Medical Ethics*" **[Auth/1]**. Section 35C(2) provides that a person's FTP shall be regarded as "*impaired*" by reason of, inter alia, "*a conviction or caution in the British Islands for a criminal offence*". By rule 34(3) of the General Medical Council (Fitness to Practise) Rules Order in Council 2004 **[Auth/2]**, "[p]*roduction of a certificate purporting to be under the hand of a competent officer of a Court in the United Kingdom… that a person has been convicted of a criminal offence… shall be conclusive evidence of the offence committed*".

11. By section 35D(2), where the MPT find that a person's FTP is impaired they may, if they think fit—

(a) direct that the person's name be erased from the register;

(b) direct that his registration in the register shall be suspended (that is to say, shall not have effect) during such period not exceeding twelve months as may be specified in the direction; or

(c) direct that his registration shall be conditional on his compliance, during such period not exceeding three years as may be specified in the direction, with such requirements as the MPT think fit to impose for the protection of members of the public or in his interests.

12. By section 35D(4) and (4A), where the MPT have given a direction that a person's registration be suspended, the MPT may direct that the suspension be reviewed by another MPT prior to the expiry of the suspension. By paragraph 10(1) of Schedule 4 to the 1983 Act, a suspension applies from the date on which the registrant's time to appeal expires, or when an appeal by the registrant is dismissed or withdrawn, but the MPT have a power to impose an immediate suspension (see section 38).

13. Section 35E(3A) requires the MPT to have regard to the over-arching objective in exercising a function under section 35D.

Appeal

14. Section 40 of the 1983 Act gives a registrant a right of appeal to the High Court against (relevantly) a decision of the MPT under section 35D of the 1983 Act giving a direction for erasure or suspension.

15. Section 40A of the 1983 Act grants a right of appeal to the GMC against a "*relevant decision*".[2] The definition of a relevant decision includes a decision of the MPT under section 35D giving, inter alia, a direction for suspension. Subsection (3) provides:

[2] Section 40A was inserted by the General Medical Council (Fitness to Practise and Over-arching Objective) and the Professional Standards Authority for Health and Social Care (References to Court) Order 2015, Art.17 (SI 2015/794).

"The [GMC] 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."

16. By subsection (4), consideration of whether a decision is sufficient for the protection of the public involves consideration of the matters contained in section 1(1B), namely 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.

17. Subsection (6) provides that on an appeal under section 40A, 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 MPT; or
    (d) remit the case to the MPT for them to arrange for a tribunal to dispose of the case in accordance with the directions of the court.

Guidance

18. The GMC publishes *Good Medical Practice* (2013) (**"Good Medical Practice"**) **[Auth/23]** which sets out the professional values, knowledge, skills and behaviour required of a doctor working in the United Kingdom.

19. The MPT (and the Divisional Court) had regard to the GMC's *Sanctions guidance* (July 2016) (**"the Sanctions Guidance"**) **[Auth/24]**.[3]

The purpose of disciplinary sanction

20. In *Bolton v. Law Society* [2004] 1 WLR 512 **[Auth/4]** Sir Thomas Bingham MR stated that a sanction imposed by a tribunal may have a number of purposes. Some orders may have a punitive element but this is unlikely to be so where a criminal penalty has

[3] We have not set out the relevant extracts in this skeleton argument. They are referred to in the judgment of the Divisional Court and will be included in the authorities bundle.

been imposed and satisfied, as "*the solicitor has paid his debt to society. There is no need and it would be unjust to punish him again*" (page 518). An order may be to ensure that the offender does not have the opportunity to repeat the offence. Or the order may have the "*most fundamental* [purpose] *of all*", namely "*to maintain the reputation of the solicitors' profession as one in which every member, of whatever standing, may be trusted to the ends of the earth. To maintain this reputation and sustain public confidence in the integrity of the profession it is often necessary that those guilty of serious lapses are not only expelled but denied readmission… A profession's most valuable asset is its collective reputation and the confidence which that inspires*". The Judge also noted that the "*reputation of the profession is more important than the fortunes of any individual member*" (page 519).

21. These principles have been applied to proceedings before the GMC. Thus in *Fatnani v. General Medical Council* [2007] 1 WLR 1460 (CA) **[Auth/14]** the Court of Appeal observed that "*a principal purpose of the Panel's jurisdiction in relation to sanctions is the preservation and maintenance of public confidence in the profession rather than the administration of retributive justice*", per Laws LJ [19].

22. Maintaining public confidence in the profession does not, however, require the imposition of disproportionate sanctions. To the contrary:

    (i) In *Bijl v. General Medical Council* [2001] UKPC 42; [2001] 65 BMLR 10 **[Auth/7]** the Privy Council stated that the concern to protect public confidence in the profession "*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*" [13].

    (ii) Similarly, in *Giele v. General Medical Council* [2005] EWHC 2143 (Admin); [2006] 1 WLR 942 **[Auth/12]** Collins J stated [29]:

> "I do not doubt that the maintenance of public confidence in the profession must outweigh the interests of the individual doctor. But that confidence will surely be maintained by imposing such sanction as is in all the circumstances appropriate. Thus in considering the maintenance of confidence, the existence of a public interest in not ending the career of a

competent doctor will play a part. Furthermore, the fact that many patients and colleagues have, in the knowledge of the misconduct found, clearly indicated their views that erasure was not needed is a matter which can carry some weight in deciding how confidence can properly be maintained…"

23. In the instant case, the Divisional Court held that *Bijl* was no longer good law having been superseded by the decisions in *General Medical Council v Jagjivan and PSA* [2017] EWHC 1247 (Admin); [2017] 1 WLR 4438 **[Auth/19]**, *Fatnani* and *Bolton* **[DC/39]**. That observation is wrong for the following reasons:

(i) The Divisional Court stated that *Bijl* was "*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*" **[DC/39]**. But that is precisely how the Privy Council considered the matter. The Privy Council noted that the Committee was "*rightly concerned with public confidence in the profession and its procedures for dealing with doctors who lapse from professional standards*", before noting that the registrant was not a danger to the public [13].

(ii) The principle expounded in *Bijl* has not been doubted in the cases cited by the Divisional Court or indeed in any other case.

(iii) In any event, the effect of the Privy Council's comments in *Bijl* is that the sanction must be appropriate and necessary in the public interest, not excessive or disproportionate, and further, that other factors may be relevant when considering what sanction is required to maintain public confidence in the profession. That is an entirely correct proposition (see *Ghosh v. General Medical Council* [2001] 1 WLR 1915 (PC) [34] **[Auth/8]**).

24. Issues regarding public confidence in the profession should be assessed by reference to the standard of the "ordinary intelligent citizen", namely one who appreciates the consequences of each sanction proposed, as well as the other issues involved in the case (see *R (Wallace) v. Secretary of State for Education* [2017] EWHC 109 (Admin); [2017] ELR 237 **[Auth/20]** per Holgate J [92]). We note that there is no statutory

foundation for that formulation, but submit that it is a sensible and workable starting point for a consideration of the characteristics of the relevant constituency for the purposes of determining the effect of a given sanction on public confidence.[4]

Test on an appeal

25. In *Jagjivan* Sharp LJ summarised the principles applicable to section 40A appeals. These are set out in the judgment of the Divisional Court **[DC/8]**. Critical to this appeal, however, is Sharp LJ's proposition (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* [2017] 1 WLR 169, at paragraph 36."

26. In *Khan* the Supreme Court cited *Marinovich v. General Medical Council* [2002] UKPC 36 **[Auth/9]** with approval, in which the Privy Council stated that "*the Professional Conduct Committee*[5] *is the body which is best equipped to determine questions as to the sanction that should be imposed in the public interest for serious professional misconduct. This is because the assessment of the seriousness of the misconduct is essentially a matter for the committee in the light of its experience. It is the body which is best qualified to judge what measures are required to maintain the standards and reputation of the profession*" [28].

27. The degree of deference may vary according to the nature of the decision taken. In *Ghosh*, Lord Millett stated that the Privy Council "*will accord an appropriate measure of respect to the judgment of the committee*… [b]*ut the Board will not defer to the committee's judgment more than is warranted by the circumstances*" [34]. Thus in

[4] A phrase such as "fully informed and reasonable observer" would also be appropriate; nothing really turns on the different language.

[5] One of the statutory predecessors to the MPT.

Council for the Regulation of Healthcare Professionals v. General Medical Council and Southall [2005] EWHC 579 (Admin); [2005] 84 BMLR 7 **[Auth/11]** Collins J stated [11] (and see also *Dad v. General Dental Council* [2000] 1 WLR 1538 **[Auth/6]**, 1542-1543):

> "… where there is misconduct constituted by a failure to reach proper standards in treating patients, the expertise of the tribunal in deciding what is needed in the interests of the public is likely to carry greater weight… But where, for example, dishonesty or sexual misconduct is involved, the court is likely to feel that it can assess what is needed to protect the public to protect the public or to maintain the reputation of the profession more easily for itself and thus attach less weight to the expertise of the tribunal…" (and see *Dad v. General Dental Council* [2000] 1 WLR 1538, 1542-1543)

III. FACTUAL BACKGROUND

Background

28. On 18 February 2011 Patient A, a six year old boy, was admitted to the Children's Assessment Unit (**"the CAU"**) at the Hospital. Patient A was admitted to the CAU suffering from diarrhoea, vomiting and difficulty in breathing. The Appellant was responsible for the care of Patient A.

29. At the material time, the Appellant was a Paediatric Specialist Registrar employed by the University Hospitals of Leicester NHS Trust (**"the Trust"**). The Appellant was in year 6 of her postgraduate training, and on that day, was the most senior doctor present on the CAU.

30. Patient A died later on 18 February 2011. The circumstances are summarised by the MPT in the Impairment Determination **[I/5-7]**.

31. In December 2014 the Appellant (along with two nurses) was charged with the gross negligence manslaughter of Patient A. Prior to that date:

    (i) The Appellant continued in her employment with the Trust. She had a 3 month period of supervised practice immediately after the death of Patient A, after which all of her consultant supervisors were content that she return to full-

duties, including on-call, see [2015] EWHC 1277 (QB) **[Auth/16]** per Knowles J [9].

(ii) The matter first came to the attention of the GMC in April 2012, but it took no steps at that stage to suspend the registration of the Appellant, see [2015] EWHC 1277 (QB), per Knowles J [6].

32. After she was charged, the Trust continued to employ the Appellant. On 8 January 2015 the Interim Orders Panel of the GMC made an interim order suspending the Appellant's registration for 18 months pending a final determination by the GMC of her FTP. On 24 March 2015 Knowles J allowed the Appellant's appeal against the interim order, [2015] EWHC 1277 (QB). After, and until her trial, the Appellant's employment continued to include a patient-facing role, in a neo-natal ward.

33. On 4 November 2015 the Appellant was convicted by 10-2 majority verdict of the manslaughter by gross negligence of Patient A **[SB/165]**. A nurse, Nurse Amaro, who was on duty alongside the Appellant was similarly convicted of manslaughter by gross negligence. The other nurse was acquitted. On 14 December 2015 Nicol J sentenced the Appellant to 24 months' imprisonment suspended for 24 months. In his sentencing remarks **[SB/166-179]**, Nicol J stated that in order to have convicted the Appellant, the jury must have been satisfied that her conduct was "*truly exceptionally bad*" **[SB/171]**, but that the jury had convicted on the basis that her failures led Patient A to die significantly sooner than he would have done (rather than on the basis that her failures significantly contributed to his death) **[SB/174]**. Nicol J also stated that there was no evidence that the Appellant had neglected Patient A because she was lazy or that she had behaved for other selfish reasons **[SB/175]**.

34. On 8 December 2016 the Court of Appeal dismissed the Appellant's renewed application for permission to appeal against her conviction, [2016] EWCA Crim 1841 **[SB/151-161]**.

The MPT determination on impairment

35. In a determination dated 20 February 2017 the MPT found that the Appellant's FTP was impaired by reason of her conviction (as was conceded by the Appellant) **[I/13]**. The MPT concluded:

    (i) The Appellant's actions fell far below the standards expected of a competent doctor at her level, and put Patient A at unwarranted risk of harm in that they led to him dying sooner than he otherwise would have **[I/18]**.

    (ii) The Appellant's actions and her resulting conviction brought the profession into disrepute and breached a fundamental tenet of the medical profession relating to good clinical care **[I/18]**.

    (iii) The Appellant's clinical failings were capable of being remediated, and that the Appellant had undergone significant remediation and reflection directly related to the concerns arising. The MPT also noted that the Appellant had continued to practise without further incident, and that there were no concerns prior to this event. It was therefore satisfied that the risk of the Appellant placing a patient at unwarranted risk of harm in the future was low **[I/19]**.

    (iv) The MPT considered that the risk of the Appellant's clinical practice suddenly and without explanation falling below the standards expected on any given day is no higher than for any other reasonable doctor **[I/20]**.

    (v) In reaching the foregoing conclusions, the MPT rejected the GMC's case that the Appellant's conduct demonstrated that there was an ongoing risk to patient safety [**I/12 and 20**].

    (vi) The MPT considered that public confidence in the profession would be undermined if a finding of impairment were not made. Such a finding was also necessary in order to promote and maintain proper professional standards and conduct for members of the profession **[I/23]**.

The MPT determination on sanction

36. A reconvened hearing took place before the MPT on 12 and 13 June 2017. The GMC contended that the only suitable sanction was erasure **[S/3]**. The Appellant contended that the appropriate sanction was a suspension **[S/8]**.

37. The MPT directed itself in accordance with the over-arching objective **[S/15]**. It had regard to the Sanctions Guidance and its own findings in the Impairment Determination **[S/14]**.

38. The MPT identified the following mitigating factors **[S/18]**: (i) the Appellant's otherwise unblemished record as a doctor; (ii) that she was of good character prior to her offence; (iii) that she remained employed by the Trust up until her conviction in 2015; (iv) that there was no evidence of concerns being raised regarding her clinical competence before or after her offence; (v) the length of time which has passed since the offence; (vi) that before 18 February 2011, she had recently returned from maternity leave and whilst she had completed some on-call shifts, this had been her first shift in an acute setting; (vii) on 18 February 2011 she was covering the CAU, the emergency department and the ward; (viii) the multiple systemic failings in the Trust's investigation (on which, see below); and (ix) that there was no evidence to suggest that her actions on 18 February 2011 were deliberate or reckless.

39. The MPT identified the following aggravating factors **[S/19]**: (i) Patient A was vulnerable by reason of his age and disability; (ii) the Appellant's failings in respect of Patient A were numerous, continued over a period of hours and included her failure to reassess Patient A following her initial diagnosis or to seek assistance from senior consultants; and (iii) even though she had expressed her condolences to the parents of Patient A, there was no evidence that she had subsequently apologised to them.

40. In considering suspension, the MPT had regard to the oral evidence of Dr Cusack, who explained that a Trust investigation had highlighted "*multiple systemic failures…* [including] *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*" **[S/28]**.

41. The MPT accepted the evidence of Dr Cusack that the Appellant had "*reflected deeply and demonstrated significant and substantial insight in* [her] *conversations with him*",

but it was "*unable to conclude that* [she] *had complete insight into* [her] *actions as it did not hear from* [her] *directly*" **[S/29]**.

42. The MPT cited *Bijl* **[S/30]** and concluded that a fully informed and reasonable member of the public (or an ordinary intelligent citizen) would view suspension as an appropriate sanction, given all the circumstances of the case. The MPT was therefore satisfied that the goal of maintaining public confidence in the profession would be satisfied by suspension **[S/31]**.

43. The MPT considered erasure, but concluded that it would be disproportionate as, in all of the circumstances of the case, the Appellant's actions and conviction are not "*fundamentally incompatible with continued registration*". It continued **[S/32]**:

> "… 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."

44. The MPT imposed the maximum period of suspension of 12 months, and ordered that a review of the suspension take place prior to its expiry **[S/35-36]**. The MPT imposed an immediate order for suspension.

The Divisional Court's decision

45. On 30 June 2017 the GMC lodged an appeal under section 40A of the 1983 Act contending that the MPT decision to impose a sanction of suspension was not sufficient to protect the public in the circumstances of the Appellant's case.

46. On 25 January 2018 the Divisional Court substituted the sanction of erasure for that of suspension **[DC/54]**.

IV. GROUNDS OF APPEAL

Overview

47. The Appellant advances five grounds of appeal. Each overlaps, and indeed grounds two and four are dealt with together below.

Ground one: unlawful approach to the Appellant's conviction

48. The Divisional Court rejected the GMC's submission that there should be a presumption that a conviction for gross negligence manslaughter leads to erasure from the medical register save for in exceptional circumstances (**"the Presumption"**). Rather, the Divisional Court rightly accepted that "*the issue depends on the facts and circumstances of each case, considered individually*" **[DC/40]**. This is consistent with the decision of Collins J in *R (Council for the Regulation of Healthcare Professionals) v. General Medical Council* [2004] EWHC 3115 (Admin) **[Auth/10]** who stated that a manslaughter conviction should not automatically lead to erasure [20].

49. Despite this, however, the Divisional Court in fact applied the Presumption, or an equivalent test. Thus the Divisional Court stated that where erasure was indicated "*as on any view it was here by the Sanctions Guidance*", then "*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*" **[DC/49]**. This is equivalent to stating that the default position is that the sanction should be erasure in gross negligence manslaughter cases. The Divisional Court went on to apply "*sufficiently significant*" at such a high standard that it was tantamount to the Presumption.

50. Thus the Divisional Court concluded that "*it would require rather stronger circumstances than those present for suspension to be sufficient to maintain public confidence in* [the] *profession, and its procedures for maintaining its professional standards*" **[DC/50]**. Further, the Court failed to identify what further factors might be sufficient to maintain public confidence in the medical profession, and why the factors enumerated by the MPT as mitigating factors **[S/18]** were insufficient.

51. In the light of the Divisional Court's decision it is difficult, or even impossible, to conceive of a case where a conviction for manslaughter by gross negligence by a jury would permit the MPT rationally to impose a sanction falling short of erasure. Had Parliament wished to provide for such a conviction to lead automatically to erasure, it could have done so. It follows that, by applying the Presumption, the Divisional Court erred in law.

Grounds two and four: error in approach to the roles of the jury and the MPT/error in the approach to the Hospital's systemic failings

52. The Divisional Court criticised the MPT for its approach to: (i) the systemic failures in the Hospital, and (ii) the Appellant's personal mitigation. The Divisional Court stated that both had been considered (and rejected) by the jury, and that their consideration by the MPS displayed a lack of respect for the jury's findings. Thus the Divisional Court held:

    (i) The MPT did not respect the role of the jury but had "*reached its own and less severe view of the degree of* [the Appellant's] *personal culpability*" **[DC/41]**. 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* [coming] *to its own, albeit unstated, view that she was less culpable than the verdict of the jury established*" **[DC/41]**.

    (ii) As to the systemic failings, the Divisional Court concluded that paragraph 28 of the Sanctions Determination ("*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*") could not be read "*other than as reducing* [the Appellant's] *culpability in a way which the jury rejected. Its approach is not consistent with the verdict*" **[DC/42]**.

    (iii) As to the personal mitigation referred to by the Appellant, the Divisional Court concluded that these matters had been in evidence before the jury (see the reference to pages 41-42 of the summing up) **[DC/47]**. The Divisional Court noted that they had been deployed in the Appellant's defence, and that "[a]*lthough 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" **[DC/47]**.

53. The Divisional Court's approach betrayed a misunderstanding of the relevant legal principles. Further or alternatively, it constituted a misunderstanding of what the MPT actually determined.

54. As to the law, evidence as to the circumstances in which the offence was committed may be relevant both to the issue of impairment and sanction. In *R (Campbell) v. General Medical Council* [2005] EWCA Civ 250; [2005] 1 WLR 3488 **[Auth/13**] the Court of Appeal stated [[19]-[20]:

> "19. … [e]vidence which may be relevant both to [impairment] and, if proved, mitigation, may overlap. ... the error under consideration may need to be examined in the context of a dedicated practitioner working in isolation and under huge pressure of, say, an epidemic. Such circumstances may be relevant to the question whether he should be found guilty of serious professional misconduct. It may indeed provide mitigation of circumstances, unrelated to penalty. If notwithstanding this evidence the case is proved, then precisely the same circumstances may also be relevant to mitigation of penalty.
>
> 20. In short, the same facts may on occasion impact both on the question whether the practitioner's conduct amounted to serious professional misconduct, and on the appropriate consequential sanction. Nevertheless, although the same evidence may be relevant on both questions, it does not follow that they cease to be distinct issues requiring separate determination."

55. For the same reasons, and as a matter of common sense, it does not undermine a jury's verdict in either the criminal court or in a disciplinary tribunal to have regard to the circumstances in which an offence was committed or a defendant's personal circumstances. Indeed, in a criminal court the context in which an offence is committed is directly and obviously relevant to the sentence to be imposed (see, for example, the comments of Nicol J when sentencing the Appellant that the CAU was a busy ward, that it could not limit its intake, and that there was no evidence that the

Appellant neglected Patient A as she was lazy or behaved for otherwise selfish reasons) **[SB/175]**. See also the Sentencing Council Guidelines: *Overarching Principles: Seriousness*, at paras. 1.4 to 1.7 **[Auth/25]**.[6] The same is true of personal mitigation, albeit that this may carry less weight in the professional discipline context, see *Bolton* at page 519.

56. This proposition applies with particular force when the complete picture was not before the jury. In this case the jury was provided with evidence of individual aspects of the systemic failings found by the Trust **[DC/27]**. The jury was not, however, provided with the Trust's view that the failings were such that it regarded the failings as systemic in nature, and that in consequence, it had altered its procedures. This point was noted by Nicol J in his sentencing remarks [**SB/176, at A**].

57. To do otherwise conflates the role of the jury (which determined whether Appellant had committed a particular offence on 18 February 2011) with the role of the MPT in determining what sanction should be imposed to protect the public in 2017 and thereafter.

58. When regard is had to these principles, the MPT's approach to both the systemic failings and the personal mitigation is unimpeachable. In particular, <u>first</u>, the MPT acknowledged that the certificate of conviction **[SB/165]** was conclusive evidence of the offences admitted **[I/1]**.

59. <u>Second</u>, there is no basis on which it could be concluded that the MPT in any way misunderstood the nature or seriousness of the Appellant's conviction. The MPT noted that the jury must have found the Appellant's conduct to be "*truly exceptionally bad*" **[S/6]** and that her actions "*marked a serious departure from Good Medical Practice, and contributed to Patient A's early death*" **[S/26]**. The Divisional Court engaged in an impermissible degree of reading between the lines as to what the MPT had concluded, as revealed by the Court's conclusion that the MPT had reached an

[6] We note that the Guidelines identify a hierarchy of culpability for sentencing purposes, and that negligence is the lowest level (see paragraph 1.7(iv)).

"*unstated*" view that the Appellant's culpability was less than the jury had found [**DC/41**]. The reason why such a view was unstated was because it was not held at all.

60. Indeed, the Divisional Court criticised the MPT for describing the Appellant's conduct as merely "*falling far short*" of the standards expected [**DC/43**]. The Divisional Court failed to appreciate that this was exactly the same phraseology used by Nicol J when sentencing the Appellant [**SB/171, at A-B**].

61. Third, it was open to the specialist MPT (both in law and on these particular facts) to conclude that the systemic failures operating in the Trust were relevant to both impairment and to sanction. In particular, the MPT was entitled to take the view that although the jury's verdict meant that the Appellant's conduct was "*truly exceptionally bad*", the particular context of the offending was relevant to determining whether erasure was required to (i) promote and maintain public confidence in the medical profession, and (ii) to promote and maintain proper professional standards and conduct for members of that profession. Indeed, the particular context of the offending needed to be taken into account in order to assess the precise degree of culpability, making allowance for the fact that the jury had already determined that the culpability had reached a criminal standard.

62. The relevant context here (and that reflected in **[S/28]**) is that the systemic safety nets capable of mitigating or avoiding completely the adverse effects of serious personal failure had been absent. To put it another way: there is a difference between context that was relevant to the level of personal failure, and context which is relevant to the circumstances in which that personal failure occurred and which might have avoided or mitigated the outcome. Considering the latter is not to reduce the Appellant's personal culpability to a level below that found by the jury (as suggested by the Divisional Court **[DC/46]**), but it is to contextualise her failings. Most importantly, it was open to the MPT, as an expert tribunal, to conclude that an ordinary intelligent citizen would regard the systemic failings as being relevant to the question that the MPT had to determine when considering sanction, namely what sanction was required to promote and maintain public confidence in the profession/proper professional

standards and conduct for members of the profession. Indeed, given that such evidence was relevant to the sentence considered by Nicol J, it must necessarily have been relevant to the sanction considered by the MPT.

63. Fourth, it was open to the MPT to have regard to the Appellant's personal mitigation. That is even more obviously so when the key elements of personal mitigation advanced by the Appellant (that she had subsequently addressed the specific failings that arose from the offence and that she had practised safely since) were of no relevance to the task performed by either the jury or Nicol J.

Ground three: the Divisional Court unlawfully substituted its judgment for that of the MPT

64. The Divisional Court unlawfully substituted its own judgment as to the appropriate sanction to impose on the Appellant for that determined by the MPT. In so doing, it erred in law.

65. As set out above, the case law requires a court to be diffident in interfering with the view of an expert MPT, particularly when the case concerns (i) conduct (as here, because despite being a conviction, it concerned clinical performance[7]), and (ii) what sanction is required to promote and maintain public confidence in the profession/proper professional standards and conduct for members of the profession.

66. The Divisional Court's approach constituted an exercise in re-sentencing. In particular, the Divisional Court's view that "*rather stronger circumstances than those present*" were required for a sanction that fell short of suspension was contrary to the considered view of the MPT as to why that sanction was not required on the facts of this case **[S/32]**.

67. The Divisional Court proceeded to weigh the balance as to sanction for itself. Thus it accepted that the fact that the specific failings arose suddenly and unexpectedly on 18 February 2011, and that the Appellant had practised safely and competently for many

[7] *C.f.* FTP cases following criminal convictions for offences of violence or dishonesty.

years before and after that date are factors which would weigh with an ordinary intelligent citizen **[DC/52]**. But the Divisional Court would have struck the balance in a different place: greater weight ought to have been given to what it saw as the verdict of the jury **[DC/53]**. In substituting its view as to where the balance ought to be struck for that of the MPT, the Divisional Court erred in law.

68. The Divisional Court's own assessment of the seriousness of this case was, in any event, flawed. Its conclusion that it was well-placed to assess the verdict of the jury was wrong. In particular, the Divisional Court failed to appreciate that:

    (i) Gross negligence manslaughter cases cover a spectrum of seriousness (notwithstanding that each case must involve the defendant's conduct being "truly exceptionally bad"): *Garg v. R* [2012] EWCA Crim 2520, [2013] 2 Cr.App. R. (S.) 30, at [6] **[Auth/15**].

    (ii) Convictions for gross negligence manslaughter "*almost invariably require immediate custodial sentences*" (or that "*custodial sentences in gross negligence manslaughter cases are almost inevitable*"), see *R v. Babamiri* [2015] EWCA Crim 2152 at [37] **[Auth/17]**.

    (iii) The relative seriousness of the Appellant's offence was assessed by the trial judge at the sentencing stage. Nicol J's decision to suspend the Appellant's sentence was an exceptionally lenient course (see *Garg* (*supra*) at [41]-[45] and *Babamiri* at [37]). The decision to suspend was based in substantial part on "*the circumstances of your offences*" [**SB/179, at A**]. The only reasonable conclusion is that Nicol J regarded *this* case of gross negligence manslaughter as being at the very lowest end of the spectrum of seriousness. See also [**SB/174, at F-G**].

Ground five: irrationality

69. The Divisional Court erred by reaching an irrational conclusion. No reasonable court could have concluded that the <u>only</u> sanction open to the MPT to promote and maintain public confidence in the medical profession, and proper professional standards and conduct for members of that profession on the facts of this case was erasure given:

(i) The benign view of the Appellant's culpability taken by Nicol J following the conclusion of the criminal trial;

(ii) The Appellant had practised safely as a doctor for almost four years following the death of Patient A;

(iii) The Appellant had remediated the deficiencies in her clinical skills;

(iv) The risk of the Appellant putting a patient at unwarranted risk of harm in the future was no higher than in the case of any other competent doctor;

(v) The MPT ordered a review before the Appellant returned to practice following the suspension; and

(vi) If the Appellant were permitted to return to practice after the review, it would be more than 7 years since the death of Patient A.

70. The MPT concluded that suspension was an appropriate sanction which was necessary in the public interest. That conclusion was within its margin of judgment and was rational. Indeed, the MPT's conclusion was correct. The ordinary intelligent citizen recognises that NHS doctors work under intense pressure in environments where systems are less than perfect and where one-off mistakes may have tragic consequences. The same citizen recognises that to err is human and that public confidence places a greater value on remediation and redemption than on retribution.

V. CONCLUSION

71. For the reasons set out above, the appeal should be allowed.

JAMES LADDIE QC

SARAH HANNETT

Matrix

1 March 2018

Perfected on 20 June 2018

Tim Johnson

Tim Johnson/Law