The Case of Dr Bawa-Garba – Where does the buck stop?

The case of Hadiza Bawa-Garba has left all of us in the UK medical profession with an uncomfortable taste in our mouths. We all know that we work under pressure and we will inevitably make mistakes. We all know that the system is under strain and as part of a team we would hope that the wider team of the NHS would back us up. Dr Bawa-Garba was working under very challenging conditions, however, we cannot take away from the fact that errors were made and her duty of care to poor Jack Adcock was breached. If you or I were the parent would we accept that the stresses and strains of a stretched system were partially responsible for his death or would we look to the doctor who was caring for him to blame?

I personally have great sympathy for Dr Bawa-Garba. She was convicted of gross negligence manslaughter in 2015 after the death of six-year-old Jack Adcock from sepsis at Leicester Royal Infirmary. She was working under intense pressure and a perfect storm of errors and omissions occurred. The consultant who was supposed to be her safety net seems to have avoided all blame. As an on-looker looking in I do not believe she should have been found guilty of gross negligent manslaughter.

The story

A six-year-old boy is admitted to the Children's Assessment Unit (CAU) at Leicester Royal Infirmary following a referral from his GP. Jack Adcock, who had Down's Syndrome and a known heart condition, had been suffering from diarrhoea, vomiting and had difficulty breathing.

Dr Hadiza Bawa-Garba was a Specialist Registrar in year six of her postgraduate training (ST6) with an 'impeccable' record. She had recently returned from maternity leave and this was her first shift in an acute setting. She was the most senior doctor covering the CAU, the emergency department and the ward CAU that day. She saw Jack at about 10.30am.

Jack was receiving supplementary oxygen and Dr Bawa-Garba prescribed a fluid bolus and arranged for blood tests and a chest x-ray. At 10.44am the first blood gas test was available and showed a worryingly high lactate reading. The x-ray became available from around 12.30pm and showed evidence of a chest infection.

Dr Bawa-Garba was heavily involved in treating other children between midday and 3pm, including a baby that needed a lumbar puncture. At 3pm Dr Bawa-Garba reviewed Jack's x-ray (she was not informed before then that it was available) and prescribed a dose of antibiotics immediately, which Jack received an hour later from the nurses.

A failure in the hospital's electronic computer system that day meant that although she had ordered blood tests at about 10.45am, Dr Bawa-Garba did not receive them until about 4.15pm. It also meant her junior was unavailable by this time.

During a handover meeting with the on-call consultant which took place at about 4.30pm, Dr Bawa-Garba raised the high level of C-reactive protein (CRP) in Jack's blood test results and a diagnosis of pneumonia, but she did not specifically ask the consultant to review Jack. She said Jack had been much improved and was "bouncing about". At 6.30pm, she spoke to the consultant a second time, but again did not raise any specific concerns.

When she wrote up the initial notes, she did not specify that Jack's enalapril (for his heart condition) should be discontinued. Jack was subsequently given his evening dose of enalapril by his mother after he was transferred to the ward around 7pm.

At 8pm a 'crash call' went out and Dr Bawa-Garba was one of the doctors who responded to it. On entering the room she mistakenly confused Jack with another patient who had a Do Not Resuscitate (DNR) order and called off the resuscitation. Her mistake was identified within 30 seconds to two minutes and resuscitation continued. This slight delay was not deemed to have contributed to Jack's death, as his condition was already too far advanced. At 9.20pm, Jack tragically died.

2 November 2015: Portuguese agency nurse, 47-year-old Isabel Amaro, of Manchester is given a two-year suspended jail sentence for manslaughter on the grounds of gross negligence. She is struck off.

4 November 2015: At Nottingham Crown Court Dr Bawa-Garba is convicted of manslaughter on the grounds of gross negligence.

14 December 2015: Dr Bawa-Garba is given a 24 month suspended sentence.

8 December 2016: Dr Bawa-Garba's appeal against her sentence is quashed at the Court of Appeal.

13 June 2017: The Medical Practitioners Tribunal Service (MTPS) says Dr Bawa-Garba should be suspended for 12 months and rejects an application from the General Medical Council (GMC) to strike her off the register. It says: "In the circumstances of this case, balancing the mitigating and aggravating factors, the tribunal concluded that erasure would be disproportionate."

8 December 2017: The GMC takes the MPTS to the High Court and argues its own tribunal was 'wrong' to allow Dr Bawa-Garba to continue to practise.

25 January 2018: The GMC successfully appeals at the High Court bid to have the MPTS decision overruled, leading to Dr Bawa-Garba being struck off the medical register. Lord Justice Ouseley says: "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." Health Secretary Jeremy Hunt says that he is "deeply concerned" about its implications.

31 January 2018: Dr Bawa-Garba's defence body releases a statement saying e-portfolio reflections were not used against her in court, despite 'wide misreporting' that they were.

7 February 2018: Following a crowd funding campaign, which raised over £335,000, Dr Bawa-Garba decides to appeal the ruling, and considers appealing the manslaughter conviction from 2015.

The case sparked understandable anger within the medical community. Two issues raised significant ire: the criminalisation of clinical error and the use of professional reflection as a stick to beat doctors with.

What the judges said when they overturned the MPTS's failure to erase Dr Bawa-Garba

In the judgment the court ruled that Dr Bawa-Garba's original sanction of

suspension should be replaced with a decision to remove her from the medical register.

Lord Justice Ouseley said: "I 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.

"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 and failings of others, and then came to its own, albeit unstated, view that she was less culpable than the verdict of the jury established."

So what did Dr Bawa-Garba do that was so wrong?

The best way to explain this is to take text directly from the judgment of GMC vs Bawa-Garba which is available in its entirety at **LINK**. I would encourage you to read it so you have the complete picture.

To prove gross negligence, the Crown relied on Dr Bawa-Garba's treatment of Jack when she initially assessed him on his admission to hospital and the obvious continuing deterioration in his condition which she failed properly to reassess. She was also criticised for her failure to seek advice from a consultant at any stage. Although it was never suggested as causative, the Crown also pointed to her attitude as demonstrated by the error as to whether a DNR notice applied to Jack.

It is alleged that Dr Bawa-Garba's initial assessment of Jack was hasty, incomplete and severely negligent. Subsequently, after receiving the results of the blood tests, she was felt to have ignored obvious clinical findings and symptoms, namely:

1. a history of diarrhoea and vomiting for about 12 hours; a patient who was lethargic and unresponsive
2. a young child who did not flinch when a cannula was inserted
3. a pyrexia but with peripheral shutdown
4. blood gas reading showing he was acidotic
5. significant lactate reading from the same blood gas test, which was extremely high
6. the fact that all this was in a patient with a history which made him particularly vulnerable.

The second set of failings on which the prosecution rested related to subsequent consultations and the failure to properly reassess Jack's condition. More particularly, these were that Dr Bawa-Garba allegedly:

1. Did not properly review a chest x-ray taken at 12.01pm which would have confirmed pneumonia much earlier.
2. 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.
3. Failed to make proper clinical notes recording times of treatments and assessments.
4. Failed to ensure that Jack was given appropriate antibiotics timeously (more particularly, until four hours after the x-ray).
5. Failed to obtain the results from the blood tests she ordered on her initial examination until about 4.15pm 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.

Reading these clinical factors I believe even an ophthalmologist with limited paediatric experience, such as myself, would recognise a very sick child. It does not take away my sympathy for Dr Bawa-Garba but I can see why criticisms were deemed to be valid and with my medico-legal hat on I can see the breach of duties.

The GMC has faced significant criticism over their actions, but they are acting in the framework of the law. If we forget the specifics of the case and consider the question in isolation – "Can a doctor convicted of gross negligence manslaughter continue to practise as a doctor?" Then the answer is surely no. Would you or I wish a doctor to care for our parents or child if they had such a conviction against them? Of course, the doctor could disclose this information but then they will always be practising with the Sword of Damocles dangling above them. It would shake the faith of the patient in that doctor and allowing doctors to continue to practise who are convicted of this crime will shake the public's faith in the profession as a whole. I need to reiterate again, as I will do throughout, that I do not believe she should have been convicted and I believe we need a shift in the law to prevent this happening again, but the fundamental fact remains that she was convicted and those who uphold the law feel that this conviction should stand.

So the GMC acted to enforce erasure because Dr Bawa-Garba was dangerous? No, it seems that was not the reason and that has caused some angst. My interpretation is that Dr Bawa-Garba was erased because the failure to erase would have damaged the confidence of the public in the medical profession and from a legal perspective the MPTS should not be able to minimise or downgrade the verdict of a jury in a court of law. Agree or not, it has brought this issue to the fore and the numerous reviews underway will shed more light on this and clarify where the medical profession stands under the hammer of the Law.

Dr Bawa-Garba's reflective notes

A lot of focus has been on the questionable use of a document intended for reflective practice and learning for personal development to apportion blame in the criminal justice process. When we reflect we are supposed to be critical of ourselves and ask ourselves what could have been done better. That is the nature of the process and encourages a practice of open self-learning and reflection. Indeed, I myself prefer to be over self-critical to truly answer the question of whether I could have done things better. To hold back and be defensive within our own reflection is counter-productive and can only lead to a worsening of our patient safety culture.

The Medical Protection Society (MPS), which represented Dr Bawa-Garba at her criminal trial, has made it clear that the doctor's reflective notes were not part of the evidence before the court and jury. The court also highlighted that no weight should be given to any remarks documented after the event. The QC who prosecuted the case for the Crown Prosecution Service also confirmed that the doctor's reflective notes did not form part of the case. So that is reassuring to some degree but it has highlighted the fact that potentially they could have been disclosable and could have been used.

Within the NHS we have sought to develop an open and honest safety culture. We report and investigate incidents, we

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develop action plans to prevent repetition, and we spread learning wider than our immediate circle by discussion with colleagues not only within the hospital, but at conferences, in the medical literature, and potentially even social media platforms. I myself am working with NHS Resolutions, the National Reporting and Learning Service and the GMC to develop robust pathways for clinician to clinician learning so we can learn from other's mistakes wherever they occur. We have a Duty of Candour so we admit mistakes to patients, involve them and inform them what we are doing to prevent errors happening again. Often those admissions are used as sticks to beat us with in litigation but we still do it. I fear that unless doctors' fears and concerns are addressed then this case will undermine all our efforts. Former Health Secretary Jeremy Hunt's statements of concern after the ruling are a welcome sign of support. Medical law has to evolve to keep up with the changes, and challenges faced, within the NHS. The law requires urgent reform to prevent individual practitioners taking the full blame for system errors and to allow us to still maximise learning from each incident.

The consultant

Reading the case, I have been struck by the lack of blame apportioned to Dr Bawa-Garbas supervising Consultant Dr O'Riordan. The court heard that O'Riordan was aware before Jack died that he had a serum pH of 7.084 and a blood lactate concentration of 11.4mmol/L, which he wrote down in his notebook at evening handover. Even as a lowly ophthalmologist, I know that that is indicative of a severely sick child. However, he did not perform a senior review of the boy because, he said, he was not specifically asked to by Bawa-Garba. He said he would have expected her to 'stress' these results to him. Are we not appointed as consultants because we are expected to pick up issues our juniors may not? If one of our trainees pointed out a patient who had an intraocular pressure (IOP) of 60mmHg would we not be expected to ask the question as to what is happening with that patient and engage with them in the management plan? Again, I have to emphasise that I believe neither Dr Bawa-Garba nor Dr O'Riordan should have faced the gross-negligent manslaughter charge, but it seems that Dr Bawa-Garba has taken the brunt of the criticism.

The Royal College of Physicians and Surgeons of Glasgow has published a practical guide for trainee doctors following these events stating that "Individuals must not be held accountable for complex systemic failure." Furthermore, Professor Sir Norman Williams, a former President of the Royal College of Surgeons of England, has been asked by the UK Government to perform an urgent review of medical malpractice cases.

So where does the buck stop?

I am seeing regular cases coming across my desk of glaucoma patients losing vision because their follow-up was delayed. This has been the subject of a National Patient Alert NPSA/2009/RRR004) [1]. Who is responsible for this avoidable visual loss? The consultant in charge of the patient? The specialist trainee who requested a six-month follow-up appointment but then failed to physically ensure it happened? The bookings clerk who placed the patient on a waiting list for an appointment rather than booking them straight in? The consultant who limited overbooking in his clinic to five extra patients and not six? Or the NHS system whereby staffing shortages mean that patients are being delayed across the board?

In ophthalmology we are fortunate in that we are unlikely ever to be in the dock charged with gross negligent manslaughter, but we are likely to make and see errors and, notwithstanding the Bawa-Garba case where the senior seems to have been absolved of guilt, as a consultant the buck usually stops with you.

As ophthalmologists we should add our voices to the calls for reforms. We do the best we can with the limited resources we have and when that 'best' is not good enough or errors occur due to the inherent pressures within the system we need to have that considered by those upholding and enforcing the law.

Sitting and examining a medico-legal case in the comfort of my study at home I can clearly see where errors happen. As we often say, the visual acuity of the retrospectoscope is 6/5 unaided. I often think "there but for the grace of God, go I" but at other times I am bewildered how certain errors could have occurred. I sadly do not take into account how busy the clinic was on that day, how the afternoon operating list was supposed to have started 30 minutes ago and the clinician is still stuck in clinic, how many patients the doctor needed to see and how many juniors were crowding the consulting room pestering the consultant with queries. If I am involved in a road traffic accident where someone has been injured, then there is a thorough investigation of the circumstances of the accident. The weather conditions, the condition of the road, the turn, the speed and a myriad of other factors are assessed and the impact of those analysed. Some of them may act as mitigating circumstances. If I am drunk at the wheel I deserve everything coming to me but an innocent accident and mistake in challenging conditions should engender leniency. Sadly, it seems that does not occur in medicine and medical law.

Former Health Secretary, Jeremy Hunt, to his credit has ordered a review into whether manslaughter laws in healthcare are fit for purpose and has been publicly critical of the GMC. We eagerly await the outcome of the review.

The challenges we face within the NHS will increase. The pressures will get harder to face. We need to put the patient at the centre of everything we do, but we need to be reassured that our diligent hard work in challenging circumstances will be appreciated. Medical law has to evolve as otherwise the very patient safety culture we have developed to protect patients will become rotten and unfit for purpose. We wish to adopt an air industry type culture of openness and no blame and yet blame seems rife in all aspects of our work. Progress is needed but it needs the input of all stakeholders.

Reference

1. Learning from patient safety incidents. NHS Improvement. http://www.nrls.npsa.nhs.uk/resources/?entryid45=61908

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