Minutes of the Fourth Ordinary Meeting

Held on Thursday 24th January 2019

Joint Meeting with the Merseyside Medico-Legal Society

'Doctors in the Dock: when the Medical and Legal Communities Collide, the Bawa Garba case'

Speakers:
Mr Shannon Eastwood (SE), Barrister, Atlantic Chambers, Liverpool

Dr Richard Hughes (RH), Consultant in Emergency Medicine, Aintree University Hospital, Mersey EM Training Programme Director ST3-6

RH began by outlining the events at Leicester Royal Infirmary of the 18th February 2011 when 6 year old Jack Adcock was brought children's acute assessment unit thought to be suffering from acute gastroenteritis and dehydration. This presentation arose against a background medical history that included Downs syndrome.

Dr Bawa Garba had just returned to hospital training after a year's maternity leave which had been preceded by 3 years paediatric training in the community. She hadn't worked in a hospital environment for 4 years and had never worked at this hospital. She examined Jack at 10.30 and found him to be acidotic and arranged for intravenous rehydration. By 11.00 Jack was thought to be improving and although his blood gases were improving he remained acidotic. However, at that time there was an IT failure in the hospital leading to a failure to flag up abnormal results. By 1500 Jack was drinking but a chest X-ray suggested bronchopneumonia. He had been receiving enalapril but Dr Bawa Garba cancelled this prescription because of concerns that it might exacerbate the presenting condition. By 16.00 his CRP (C reactive protein, a marker of acute inflammation and sepsis, normally <5) was elevated at 97 and there was biochemical evidence of acute kidney injury.

During this time Dr Bawa Garba had been rostered to look after the paediatric ward inpatients. Dr O'Riordan, the paediatric consultant meant to be present on the children's acute assessment unit was lecturing at another hospital and the paediatric registrar rostered to attend the children's acute assessment unit had been given study leave and so Dr Bawa Garba was, in addition to her own job, also standing in for these other two doctors, and without senior supervision. When Dr O'Riordan returned at 16.30 Dr Bawa Garba handed over the patients on the assessment unit to him but Dr O'Riordan didn't see Jack.

At 19.20 Jack was admitted to ward 28 and was re-prescribed enalapril, following which he rapidly deteriorated. He was being looked after by an agency nurse with no paediatric experience. At 20.20, some 11 hours after his initial presentation he suffered a cardiac arrest from which he couldn't be resuscitated and he passed away at 21.21. When the cardiac arrest team were initially called Dr Bawa Garba was concerned that the arrest call related to a child who was terminally ill which led to a delay in them getting to Jack's bedside.

A Serious Untoward Incident Investigation (SUII) was convened and Dr O'Riordan said he had never been informed of the severity of Jack's condition. One week later Dr Bawa Garba met Dr O'Riordan informally to reflect on these events but was reluctant to sign off her reflection document. Five months later Dr O'Riordan resigned and moved to Ireland.

SE then continued that the SUII had identified 6 issues of concern and a year later, in February 2012 the police became involved but concluded a month later that no charges would be made. However, at Jack's inquest in July 2013 the Coroner on the basis of evidence from ab independent paediatric expert concluded that his death was due to negligence and referred the matter to the Crown Prosecution Service. As a consequence, Dr Bawa Garba was charged with gross negligence manslaughter in December 2014. It was alleged that she was not sufficiently aware of the fluid loss due to the diarrhoea (not charted by the agency nurse), not aware of the blood results (via the IT system that wasn't working), failed to appreciate the degree of sepsis and renal failure, failed to seek consultant advice (regardless that the

consultant being off site), and inappropriately stopped Jack's resuscitation (because of confusion with the adjacent terminally ill child).

At her trial in November 2015, in the judge's guidance to the jury while not including the 79 recommendations of the SUII report, asked the Jury to consider Dr Bawa Garba's guilt with regard to each of the allegations. Expert evidence to the court was provided by an adult intensive care specialist. She was found guilty by a 10/2 majority verdict and at the later sentencing hearing was sentenced to a 2 year prison sentence, suspended for 2 years and told to contribute £25,000 towards the prosecution costs. Dr Bawa Garba appealed her conviction but this was refused as it was concluded that the jury guidance was sound. In June 2017 she was suspended for 1 year by the Medical Practitioners Tribunal Service (MPTS), but following a petition organised by Jack's parents, the GMC applied to the High Court to overturn the MPTS decision and as a result Dr Bawa Garba was permanently struck off. This judgement was backed up by the High Court in January 2018 but following a crowd funded (#IAMHADUZA) further appeal was overturned by the Court of Appeal in August 2018.

RH then continued, there was clearly a conflict between the parents supported by the tabloids and the doctors who understood and sympathised with the situation Dr Bawa Garba found herself in on that day. There were clear organisational systems failures comprising staff shortages (including responsible consultant being some distance off site), inexperienced team members, and poor team communication. The GMC responded with new advice to juniors on acting on concerns about issues of patient safety and to contact them directly if not satisfied with the local response. Furthermore, the GMC reviewed its guidance on reflective protocols to advise that they should reflect on learning from relevant events.

SE concluded with a review of the current state of gross negligence manslaughter including R -v- Ademoko (1994). Over the last few years 23 of 37 practitioners had been convicted but 4 of these convictions had been overturned on appeal. This is very small when compared to the number of cases investigated for possible gross negligence manslaughter, however these prosecutions have been decreasing since 2013. The problem for doctors is the fear of prosecution versus the fear of conviction. The judge ruled at the conclusion of R -v- Rose that the circumstances of the breach of duty had to be truly exceptionally bad and so reprehensible as to justify the conclusion that it amounted to gross negligence and was therefore a crime.

The review by Professor Sir Norman Williams (past-President of the RCS England) in 2018 reviewed contemporaneous guidance to professional bodies and the GMC's right to review decisions of the MPTS was removed. No longer would registered doctors be required to submit reflective material to investigative bodies and that investigative bodies should undergo formal training in investigative process. The recommendations of this review have been adopted by the then Secretary of State for Health.

Mr G J Poston