



BACK TO BLAME:

Bawa-Garba could have been any Specialty Trainee

JS Bamrah ¹, Ramesh Mehta ²

1 Consultant Psychiatrist and Honorary Professor; National Chairman, British Association of Physicians of Indian Origin (BAPIO). 2 Consultant Paediatrician; Founder and President, BAPIO.

Jsbamrah@aol.com

cite as: Bamrah JS, Mehta R. (2018) Back to Blame: Bawa-Garba could have been any specialty trainee. *Sushruta* 11(1):9-12 DOI: [10.38192/11.1.3](https://doi.org/10.38192/11.1.3)

Introduction

The death of Jack Adcock in 2011 made headlines all around the world for many reasons. He was a 6-year-old child, admitted to Leicester Royal Infirmary (LRI) in February 2011 who died of sepsis and pneumonia 11 hours later. The paediatric registrar Dr Hadiza Bawa-Garba had failed to diagnose his condition, resulting in criminal proceedings and her erasure from the medical register in 2017. This article gives a glimpse of the controversial case, tries to relate this to all medical specialties and offers some guidance on how to avoid a similar situation developing.

Dr Bawa-Garba's background

Dr Bawa-Garba had dedicated her life to improving patient health from an early age. As a young student, from the age of thirteen she had volunteered in Africa. During her holidays, after school and at the weekends, she had worked at hospitals and AIDS clinics. She continued her charitable work as a medical student and later as a doctor by raising funds for benevolent causes and awareness of matters, mainly HIV/AIDS and organ donation. She used her unique position to provide necessary and effective health information to women in underprivileged communities.

She received a first-class degree in Physiology and Pharmacology from the University of Southampton, where she also received the Physiology Society Prize and went onto study medicine, receiving outcomes of 'Merit' and 'Excellent' in many modules including in her finals. She continued to perform over and above average by contributing to excellent audit projects and guidelines, of high enough standard to be incorporated in working databases. She was popular with patients, families, nurses and fellow medics.

Events of 11th February 2011

On 11th February 2011, Jack was referred to LRI by his GP and admitted to a Children's Assessment Unit. He had a known heart condition and Down's syndrome. He presented with diarrhoea, vomiting and difficulty breathing.



He was treated by Dr Bawa-Garba, an ST5 specialist registrar. She had recently returned from maternity leave and was alone in charge of the emergency department and Children's Assessment Unit on the day. Rota gaps had meant that she had to cover the work of two other doctors and the on-call consultant was lecturing off-site and was unavailable to her.

She was in an unfamiliar setting, leading an inexperienced team, and covering the workload of three doctors (absent registrar and consultant, and her own role) as well as that of her SHO during the afternoon who was delegated to do telephone calls for results due to computer system breakdown. She was covering multiple areas, spanning four floors in the hospital, as well as being tasked with advice on paediatric patient matters external to her direct cover ward areas and to the wider community. The nursing team were also hard-pressed to make full observations and due to pressures on beds patients were moved between ward areas and given medications without Dr Bawa- Garba's awareness.

Jack had a complex clinical picture. Even senior experienced doctors undertreat severe sepsis in over 60 % of cases in the first twelve hours in the UK. She prescribed fluids, oxygen and antibiotics in line with guidelines and her initial treatment was acknowledged as good by the investigators of the case.

Jack died of a cardiac arrest as a result of sepsis at 9.20pm.

Legal proceedings:

On 2 November 2015, agency nurse Isabel Amaro was sentenced to a 2-year suspended jail sentence, having been found guilty of manslaughter by gross negligence. Her monitoring of Adcock's condition and record-keeping were criticised. She was subsequently struck off the nursing register. The ward sister Theresa Taylor was also charged but acquitted.

On 4 November 2015, Dr Bawa- Garba was found guilty of manslaughter by gross negligence. The following month, she was given a 2-year suspended jail sentence. She appealed against the sentence, but the appeal was denied in December 2016.

The Medical Practitioners Tribunal Service suspended Dr Bawa-Garba for 12 months on 13 June 2017. The General Medical Council's (GMC) successful appeal to the High Court resulted in her being struck off the medical register on 25 January 2018. There was national outrage and a tsunami of protests from doctors across the world to the case. A crowdfunding campaign by 'Team Hadiza' ensued, resulting in over £350,000 being raised to support her in her fight against erasure. A separate legal team was appointed, and legal evidence was also submitted by BAPIO and the BMA as interested parties to the case.

The Master of the Rolls Sir Terence Etherton sat in judgment, along with Lord Chief Justice Lord Burnett and Lady Justice Rafferty¹. In another twist to the tale, after the final hearing, he pronounced on the 13th August 2018 that the High Court had been "wrong to interfere with the decision of the tribunal." Sir Terence Etherton further stated that "The tribunal was an



expert body entitled to reach all those conclusions, including the important factor weighing in favour of Dr Bawa-Garba that she is a competent and useful doctor, who presents no material continuing danger to the public, and can provide considerable IT failure, the Trust's paediatric observation priority score tool was not sufficiently robust or easy to interpret, test results were relayed by telephone but no abnormal results were flagged up, there was a failure by nursing staff to recognise abnormal observations and record and monitor according to clinical need, the Trust process for handover between medical and nursing staff was poor, and there was a failure to communicate to the child's family the importance of not giving enalapril.

Dr. Bawa-Garba did commit a number of errors; principally, it was felt that the abnormal results should have been obvious to her, she had not alerted the on-call consultant to them, she had misdiagnosed the condition, and she had mistaken Jack for another child and stated he was not for resuscitation when he had a cardiac arrest (though this 10 October 2018 useful future service to society."

He instructed the GMC to restore her back on the medical register.

E-portfolios:

Since 2012, several concerns have been highlighted including in 2016, that for junior doctors "A large number of doctors are required to 'reflect' on Serious Incidents (SIs) and Significant Event information as part of their training. This could, therefore, create a significant administrative burden and result in cases of double jeopardy."

As required, Dr Bawa-Garba kept reflective learning material in an e-portfolio as part of her training, including relating to the treatment of Adcock. However, a major contentious issue that arose in this case was the use of this material, although to what degree has been disputed. Her defense team have stated that her e-portfolio was not used in the 2018 case. The contention amongst others is that although the e-portfolio was not used explicitly in the 2015 case, it had been seen by expert witnesses and so 'you cannot unsee what you have seen'. The GMC's own stance has been consistent, that doctors' reflections should be legally privileged.

Systemic failures:

A catalogue of clinical and administrative mishaps occurred on the day that Jack was admitted. Dr Bawa-Garba had just returned from maternity leave and did not have an induction which would have familiarised her with hospital procedures. There were rota gaps, an inexperienced nursing team was quickly recognised, and not attributed to his eventual death). The Trust's SI report identified 93 failures, of which six were attributed to Dr Bawa-Garba.

The response from doctors:

There has been outrage amongst doctors and doctors' organisation about the final verdict to erase Dr Bawa-Garba from the register². 7,500 doctors signed a petition sanctioning the GMC, and the BMA's GP committee passed a vote of 'no confidence' in the GMC.



Doctors attending the Royal College of Paediatrics and Child Health's AGM in Glasgow unanimously passed a motion stating: "This College considers [that] the criminal prosecution of dedicated doctors for gross negligence manslaughter, following systemic errors, impairs the advancement of safe healthcare for patients."

A group of 159 paediatricians wrote in *The BMJ* that they "are confident to employ Bawa-Garba with supervision in a training position upon her reinstatement to the medical register and pending her employment in a substantive post that will facilitate her return to work when she is reinstated."

The President of the Royal College of Physicians and Surgeons of Glasgow, David Galloway, stated: "I think that the profession has lost confidence in the General Medical Council. Doctors on the ground, especially younger doctors, are facing an overstretched service with sub-optimal staffing that presents patient safety concerns. This is against the background of this tragic case and they, inevitably, feeling exposed."

The BMJ stated: "We've received correspondence from readers around the world expressing their concerns about system failures, using e-portfolios in legal proceedings, and the threat to duty of candour."

Nick Ross, the journalist and TV pundit said: "I fear the time has come to hold the GMC to account. Can it show how this case has improved patient safety and standards in medicine, or - surely the only alternative - has it acted as an erudite and urbane kangaroo court?"

BAPIO accused the GMC of racial discrimination and victimising a trainee rather than understanding the pressures in the NHS. It called for the CPS to bring charges of corporate manslaughter on the Trust and referred the consultant on call that day, Dr. Stephen O' Riordan, to the GMC and the Medical Council of Ireland for investigation of his conduct.

Most significantly, Jeremy Hunt, Secretary for State for Health, posted a tweet expressing concern about the unintended consequences of the verdict and launched a rapid review immediately, which is chaired by Professor Sir Norman Williams, ex-President of the Royal College of Surgeons (England). The review will make public its conclusions this summer.

The real fear amongst doctors, and indeed other health professionals, following the conviction and erasure of Dr Bawa-Garba and nurse Amaldo is that genuine mistakes will be criminalised by the courts, thus jeopardising any learning from SIs. Furthermore, the likelihood is that many will be tempted to hide their mistakes rather than being candid, causing longer-term harm to patients and the health service.

Amongst the most prominent critics are two individuals who in our view truly stand out both in regard to criticisms of the GMC's handling of the case. Jenny Vaughan, a neurologist, the co-founder of an organisation 'Manslaughter and Healthcare' an online resource (www.manslaughterandhealthcare.org. UK), stated: "The GMC's actions here are purely punitive against a paediatrician who trusted the investigation process. It's terribly tragic that a child has died, but there are no winners in a system that blames tragic outcomes on a trainee. There was a catalogue of errors in this case, and patient safety will never be improved unless everyone promotes an open learning culture."



Jonathan Cusack, who supervised Dr Bawa-Garba and lead on a debriefing for staff affected by Jack's death, said that trainee doctors working in Leicester were concerned and angry about the conclusions of the trust's investigation and the subsequent legal process. "Trainees felt that their colleague was being scapegoated and taking the blame for a series of system failings," he said.

Implications for training – avoiding the pitfalls:

The first issue is that in the event that any doctor finds himself/herself struggling under the demands of pressure, it is vital that you call the senior manager responsible or, in the case of a trainee the consultant supervisor, to ensure that they have the support and advice they need to overcome any crisis or demand.

If essential, limit yourself to the emergency work that requires immediate action.

In the case of consultants who are on call, our advice is that they must give the trainee(s) on duty a call to ensure that they are made aware by them personally to call in the event of any issues. It offers a personal touch that cannot be achieved by simply having a name on the rota, which in some instances will be wrong anyway.

In the event of an SI, doctors would be advised to raise a DATIX entry on this, which will then generate a formal response from the Trust. Junior doctors must also additionally do Exception reporting to ensure that this event goes formally through the Guardian of Safe Working. Portfolios are now under more scrutiny than ever, and until there is absolute clarity we would urge caution in being absolutely candid about SIs. This is also true for appraisal documentation. The principle here is one that the insurance companies adopt, of not accepting any blame for an accident until the matter has been legally looked at. This is rather unfortunate but as it currently stands at the present time, all portfolios on paper or e-notes can potentially be used as evidence during trials.

The case demonstrates the need to have professional indemnity, and ensure that anyone affected is suitably supported. It threatens to change the course of medical history, with the prospect that genuine mistakes will be played out in court and punished in a criminal manner. No specialty training is immune to this sort of event, particularly those that are patient-facing where risks are an everyday occurrence and the mixture of rota gaps, agency staff, multiple demands, poor IT back up are common. All those working in this crisis-ridden NHS must be aware at all times of the robustness of the system that they work in, or they risk facing similar consequences to Dr. Bawa-Garba in the event of the death of a patient from mistakes that might have been made for genuine reasons.

Finally, trainees need to be aware that this is a highly unusual case and therefore it is unlikely, though sadly not impossible, for such a case to arise in the future. Ultimately, the public has faith that doctors act in good faith and so having the fear factor rule the practice of medicine is likely to cause more harm than good. Risk-taking remains part of perfecting the art of that practice and should rightly remain so for the future. Provided, of course, that safeguards are built into this. It remains to be seen whether the less discerning member of the public can differentiate between harm or neglect arising through wilful acts as opposed to honest mistakes.



References:

1. Hadiza Bawa-Garba v General Medical Council. (2018) EWCA CIV 1879 <https://www.judiciary.uk/judgments/bawa-garba-v-general-medical-council/>
2. BMJ coverage <https://www.bmj.com/bawa-garba>