Professor Terence Stephenson
Chair
General Medical Council

CONFIDENTIAL

23rd October 2017

Dear Professor Stephenson

We write to express grave concerns with respect to the General Medical Council's decision to appeal the Medical Practitioners' Tribunal Service recommendation regarding Dr Hadiza Bawa-Garba's suspension from practice for one year, to one of full erasure from the medical register. We would like to draw your attention also to the letter sent to you earlier this year so you are able to gain a sense of the impact of what happened to Dr Bawa Garba and how it has affected the profession.

Dr Bawa-Garba was the sole registrar covering the Children's Assessment Unit, with additional general paediatric duties at Leicester Royal Infirmary in February 18th, 2011 when a patient was admitted to hospital with fatal Group A streptococcal septicaemia. We do not in any way underestimate the personal tragedy for the patient and his family, but we write as professionals who, like Dr Bawa-Garba, have spent our working lives doing our best to combat ill health in those populations whom we serve.

We appreciate that the courts found Dr Bawa-Garba guilty of gross negligence manslaughter. The nature of the legal process is such that many factors, which had an impact on the outcome were unable to be put before the jury. The Medical Practitioners' Tribunal was able to consider salient details, unavailable to the jury. In appealing the decision of the Medical Practitioners Tribunal, we are concerned that the General Medical Council may not have been aware of this discrepancy and we wish to bring this to your attention.

A serious untoward incident inquiry was undertaken following the patient's death, which was completed 24th August 2012. A 14-person investigation team concluded that a single root cause for the death was unable to be identified. Numerous parts of the clinical process were identified as needing change. The report highlighted 23 recommendations and 79 actions that were undertaken as a result of the organisational learning from the patient's death: 3 actions were in relation to the interpretation of abnormal blood results; 7 related to the reflection and supervision of Dr Bawa-Garba; and 5 were related to her return to work after prolonged absence. The recommendations included increased educational supervision and support of medical trainees, increased consultant input to the Children's Assessment Unit, and a review of the paediatric early warning scoring system that was in place on the paediatric wards to help identify sick and deteriorating children.

The medical director, Dr Andrew Furlong, at Leicester Hospitals stated: "Following Jack's death, we carried out a full investigation and have implemented a number of improvements to our systems which have reduced the risk of such events occurring again. For example, we have increased dedicated consultant presence on the children's assessment unit and our systems for the early detection and management of patients with sepsis have changed, are routinely monitored and performance reported to the trust

board." This robust system of improved support was unavailable to trainee staff in 2011 and these "necessary" improvements may not all have been put before the jury.

When giving evidence at the Tribunal, consultant staff referred to 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.

Tribunal chair Mr Uddin stated that there was no evidence Dr Bawa-Garba's actions were "deliberate or reckless". In opting for suspension, the Tribunal took account of Dr Bawa-Garba's unblemished record before and since, and evidence from colleagues and consultants, who called her "an excellent doctor" adding "The tribunal did not consider that your failings are irremediable; indeed, it has already found that you have remedied them."

There is a significant published mortality from Group A Streptococcal disease, even in the best hands. The progress of sepsis in children can be difficult to monitor and assess, and is sometimes associated with a degree of unsustainable physiological recovery, so called "compensation". This has led to campaigns, both within the health service as well as the media, to attempt early identification and aggressive treatment of sepsis. Despite a picture of under resuscitation of severe sepsis by UK health care workers in 60% of cases in the first 12 hours after presentation, there has been debate that following sepsis pathways may lead to "over treatment" of healthy children, excess morbidity from current aggressive approaches, or over medication by antibiotics, thus showing that experienced professionals do not necessarily agree on ideal standardisation of approach. It would only be fair to "strike off" Dr Bawa-Garba if every health professional, who has ever failed to optimise treatment of sepsis in any of its varied presentations in any of the variety of conditions with which patients present, was also to be sanctioned in this manner.

We feel there is a danger when any individual health care professional is independently blamed in a situation of multiple cumulative systems errors. Punishment of health care workers does not encourage open reflection and will lead to a cover-up culture. There is a staffing crisis in many acute specialities including paediatrics and the criminalisation of clinical error serves to worsen recruitment to high risk specialities.

For all the reasons above, in our opinion, the decision of the General Medical Council to appeal the Medical Practitioners' Tribunal recommendation we believe in no way upholds the reputation of the profession or the safety of future patients. Indeed, we feel the opposite is true and that a successful appeal may simply send all the wrong signals to those wishing to enter a career in paediatrics, and indeed health care, who have been watching the sad sequence of events in this case.

As doctors, we all want to see improvements made to patients' care, and we agree with the Secretary of State's views on the importance of a 'safe space' to be able to discuss and learn from critical events. The criminalisation of multifactorial medical error is the antithesis of a just culture and will serve to worsen learning from events and ultimately patient safety.

We thank you for your kind consideration of our concerns in this matter and we also enclose another copy of the letter we sent earlier this year detailing similar concerns.

Yours sincerely,

Dr Suzi Armitage, Paediatric Specialist Trainee, East Midlands Deanery
Dr Karen Aucott, Consultant Paediatrician, Nottingham Children's Hospital
Dr Peter Barry, Consultant Paediatric Intensivist, Leicester Children's Hospital
Dr Carol Bertenshaw, Consultant Paediatrician, Nottingham Children's Hospital
Miss Beverly Cheserem, Neurosurgery Fellow, Cardiff
Dr Richard Cunningham, Consultant Microbiologist, Derriford Hospital, Plymouth Hospitals NHS Trust
Dr Jonathan Cusack, Consultant Neonatologist, Leicester Children's Hospital
Dr Lyvia Dabydeen, Consultant Paediatric Neurologist, King's College Hospital, London
Dr Elisabeth Davidson, Portfolio General Practitioner, Liverpool
Dr Louise Denvir, Consultant in Paediatric Endocrinology and Diabetes, Nottingham Children's Hospital
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Dr Hassan Gaili, Consultant Neonatologist, Hull and East Yorkshire NHS Trust
Dr Peter Garrett, Consultant Physician and Nephrologist, Londonderry, NI
Dr Clare Gerada, General Practitioner, Hurley Group
Dr Sanjay Gupta, Consultant Paediatrician, Hull and East Yorkshire NHS Trust
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Dr Kim Holt, Consultant Community Paediatrician, Whittington Health, Co-founder of *Patients First*
Dr Tom Jaconelli, Emergency Medicine Specialist Trainee, Humber and Yorkshire Deanery
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Dr Tony O'Sullivan, Consultant Community Paediatrician, Lewisham (retired)
Dr Kamal Patel, Consultant Paediatrician, Royal Alexandra Children's Hospital, Brighton
Dr Tabitha Randell, Consultant Paediatric Endocrinologist, Queen's University Hospital, Nottingham
Dr Rayessa Rayessa, Consultant Stroke Medicine, Hull and East Yorkshire NHS Trust
Dr Paul Revell, Consultant Haematologist (retired), Stafford

Dr Martin Samuels, Consultant Paediatrician, Royal Stoke University Hospital & Great Ormond Street Hospital
Professor Wendy Savage, Consultant Obstetrician (retired) & President, Keep Our NHS Public
Dr Stephanie Smith, Consultant Paediatric Emergency Medicine, Nottingham Children's Hospital
Professor David Southall, Professor of Paediatrics, Maternal & Child Healthcare Advocacy International
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Dr Sethu Wariyar, Consultant Paediatrician, St Peter's Hospital, Chertsey
Professor Shernaz Walton, Consultant Dermatologist, Hull and East Yorkshire NHS Trust
Dr Eric Watts, Consultant Physician and Chair, Doctors for the NHS
Dr Christopher Wells, Consultant Gastroenterologist, North Tees and Hartlepool
Mr Jonathan Wells, Consultant Paediatric Surgeon, Christchurch Hospital, NZ

Copies to:
Mr Charlie Massey, Chief Executive and Registrar, General Medical Council
Anna Rowlands, Assistant Director of Policy, Business Transformation and Safeguarding, GMC
Professor Neena Modi, President, Royal College of Paediatrics and Child Health,
Sir Liam Donaldson, Chair of World Alliance for Patient Safety
Professor Dame Sally Davies, Chief Medical Officer for England
Rt Hon Jeremy Hunt MP, Secretary of State for Health
Mr Harry Cayton, Chief Executive, Professional Standards Authority

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