Neutral Citation Number: [2018] EWCA Civ 1879

Case No: C1/2018/0356

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
DIVISIONAL COURT
Gross LJ and Ouseley J
[2018] EWHC 76 (Admin)

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 13/08/2018

Before :

THE LORD CHIEF JUSTICE OF ENGLAND AND WALES
THE MASTER OF THE ROLLS
and
LADY JUSTICE RAFFERTY

- -

Between :

Hadiza BAWA-GARBA	**Appellant**
- and -	
THE GENERAL MEDICAL COUNCIL	**Respondent**
-and-	
THE BRITISH MEDICAL ASSOCIATION (1) **THE PROFESSIONAL STANDARDS AUTHORITY FOR HEALTH AND SOCIAL CARE (2)** **THE BRITISH ASSOCIATION OF PHYSICIANS OF INDIAN ORIGIN (3)**	**Interveners**

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James Laddie QC and **Sarah Hannett** (instructed by **Tim Johnson/Law**) for the **Appellant**
Ivan Hare QC (instructed by **GMC Legal**) for the **Respondent**
Jenni Richards QC and **Nadia Motraghi** (instructed by **Capital Law**) for the **First Intervener**
Fenella Morris QC (instructed by **Browne Jacobson LLP**) for the **Second Intervener**
Karon Monaghan QC (instructed by **Sarah Dodds, Medical Defence Shield**) made written submissions for the **Third Intervener**

Hearing dates : 25 and 26 July 2018

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Approved Judgment

Lord Burnett of Maldon CJ, Sir Terence Etherton MR and Lady Justice Rafferty :

1. This is an appeal from the order dated 25 January 2018 of the Divisional Court of the Queen's Bench Division (Gross LJ and Ouseley J) by which it: (1) allowed the appeal of the respondent, the General Medical Council ("the GMC") from the decision of the Medical Practitioners Tribunal ("the Tribunal") on 13 June 2017 to suspend the registration of the appellant, Dr Hadiza Bawa-Garba ("Dr Bawa-Garba"), from practice for a period of 12 months; and (2) quashed that decision of the Tribunal, and substituted in its place a direction that Dr Bawa-Garba's name be erased from the Medical Register.

2. The central issue on this appeal is the proper approach to the conviction of a medical practitioner for gross negligence manslaughter in the context of fitness to practise sanctions under the Medical Act 1983 ("MA 1983") where the registrant does not present a continuing risk to patients.

The factual background

Events prior to the criminal proceedings

3. The following is a brief summary of the facts taken from the judgment of the Divisional Court and from the judgment of Sir Brian Leveson P, sitting in the Court of Appeal (Criminal Division) in *R v Bawa-Garba (Hadiza)* [2016] EWCA Crim 1841, which is sufficient to understand the factual context of this appeal. A much fuller factual account can be found in those judgments.

4. Dr Bawa-Garba is a junior doctor specialising in paediatrics. In February 2011 she had recently returned to practice as a Registrar at the Leicester Royal Infirmary Hospital ("the Hospital") after 14 months of maternity leave. She was employed in the Children's Assessment Unit of the Hospital ("the Unit"). That was an admissions unit of 15 beds which would receive patients from Accident and Emergency or from direct referrals by a GP. Its purpose was to assess, diagnose and (if appropriate) then treat children, or to admit them onto a ward or to the Paediatric Intensive Care Unit as necessary. The case concerns Dr Bawa-Garba's care and treatment of Jack Adcock.

5. Jack was six years of age in February 2011. He had been diagnosed from birth with Downs Syndrome (Trisomy 21). He was also born with a "hole in the heart", which required surgery. As a result he required long-term medication called enalapril and he was more susceptible to coughs, colds and resulting breathlessness. In the past Jack had required antibiotics for throat and chest infections, including one hospital admission for pneumonia. He was, however, well supported by a close family, local doctors and learning support assistants. He was a thriving little boy, who attended a mainstream pre-school nursery and then a local primary school. He enjoyed playing with his younger sister and was a popular and energetic child.

6. On Friday 18 February 2011 Jack's mother, Nicola Adcock, together with his grandmother, took Jack to see his GP, Dr Dhillon. Jack had been very unwell throughout the night and had not been himself the day before at school. The GP was very concerned. He decided that Jack should be admitted to hospital immediately. Jack presented with dehydration caused by vomiting and diarrhoea and his breathing was shallow and his lips were slightly blue.

7. When Jack arrived and was admitted to the Unit at about 10.15 am, he was unresponsive and limp. He was seen by Sister Taylor, who immediately asked that he be assessed by Dr Bawa-Garba, then the most senior junior doctor on duty. For the following 8-9 hours, he was in the Unit, under the care of three members of staff. At about 7.00 pm he was transferred to a ward. During his time at the Unit, he was initially treated for acute gastro-enteritis and dehydration. After an x-ray he was subsequently treated for pneumonia with antibiotics. The responsible staff were Dr Bawa-Garba, Ms Isabel Amaro, a nurse on duty at the time, and Ms Theresa Taylor, the ward sister.

8. In fact, when Jack was admitted to the Hospital, he was suffering from pneumonia (a Group A streptococcal infection) which caused his body to go into septic shock. The sepsis resulted in organ failure and, at 7.45 pm, caused his heart to fail. Despite efforts to resuscitate him (which were initially hampered by the mistaken belief that Jack was a child in the "do not resuscitate" or DNR category), Jack died at 9.20 pm.

The criminal proceedings

9. The police investigated the matter. Dr Bawa-Garba was told by the Crown Prosecution Service ("the CPS") in 2012 that no charges would be brought against her. Following the inquest into Jack's death in 2013 the CPS reviewed its decision, and in December 2014 she was told that she would after all be prosecuted. She continued to be employed at the Hospital.

10. In due course, the Crown brought charges against Dr Bawa-Garba, Ms Amaro and Ms Taylor. They were tried at Nottingham Crown Court before Nicol J and a jury in 2015.

11. The evidence at the trial was that Jack was at risk of death from his condition on admission (quantified as being in the range 4-20.8%). The clinical signs of septic shock were present in Jack at the time of admission to the Unit (cold peripheries, slow capillary relief time, breathlessness and cyanosis, lethargy and unresponsiveness). In addition, raised temperature, diarrhoea and breathlessness all pointed to infection being the cause.

12. The case for the Crown was that all three members of staff contributed to, or caused, Jack's death by serious neglect which fell so far below the standard of care expected of competent professionals that it amounted to the criminal offence of manslaughter by gross negligence.

13. The evidence for the prosecution was that the results of the initial blood tests, together with Jack's medical history, his physical condition and responses and his symptoms would have shown any competent junior doctor that Jack was in shock. There were many specific criticisms of particular failings on the part of Dr Bawa-Garba, including: failure properly to review a chest x-ray taken at 12.01 pm which would have confirmed pneumonia much earlier; failure properly to request the blood gas test; failure to ensure that Jack was given appropriate antibiotics timeously (more particularly, until four hours after the x-ray); failure to obtain the results from the blood tests she ordered on her initial examination until about 4.15 pm, and then failure properly to act on the obvious indications of both infection and organ failure from septic shock; failure to make proper clinical notes recording times of treatments and assessments; and failure to express concerns to a consultant at any stage, other than when the senior consultant, Dr Stephen O'Riordan, arrived on the ward for the normal staff/shift handover at 4.30 pm, to whom she mentioned the

high level of CRP and diagnosis of pneumonia. She said that Jack had much improved and was bouncing about. At 6.30 pm, she spoke to the consultant a second time but did not raise any concerns.

14. The case advanced on behalf of Dr Bawa-Garba at the criminal trial was that she was not at any stage guilty of gross negligence. She relied on a series of matters. Among them were that a failure in the Hospital's electronic computer system that day meant that, although she had ordered blood tests at about 10.45am, she did not receive the blood test results from the Hospital laboratory in the normal way and she was without the assistance of a senior house officer. The results were delayed despite her best endeavours to obtain them. She finally received them at about 4.15pm. Further, a shortage of permanent nurses meant that agency nurses (who included Nurse Amaro) were being used more extensively. Further, Nurse Amaro had failed properly to observe the patient and to communicate Jack's deterioration to Dr Bawa-Garba, particularly as Dr Bawa-Garba was heavily involved in treating other children between 12 and 3pm (including a baby that needed a lumbar puncture). The nurse also turned off the oxygen saturation monitoring equipment without telling Dr Bawa-Garba and, at 3pm, when Jack was looking better, the nurse did not tell her about Jack's high temperature 40 minutes earlier or the extensive changing of his nappies. Dr Bawa-Garba also said that she had prescribed antibiotics for Jack at 3pm as soon as she saw the x-rays (which she agreed she should have seen earlier), but the nurses failed to inform her that the x-rays were ready previously and then failed to administer the antibiotics until an hour after she had prescribed them.

15. Dr Bawa-Garba gave evidence in her own defence and relied on her previous good character, including positive character evidence. She had worked a double shift that day (12/13 hours straight) without any breaks and had been doing her clinical best, despite the demands placed upon her. She also called supportive expert evidence (from Dr Samuels) to the effect that septic shock was difficult to diagnose and Jack's was a complicated case in which the symptoms were subtle and they were not all present. Reliance was also placed on the conduct of Nurse Amaro (including the delay in administering the antibiotics Dr Bawa-Garba prescribed), the problems with the computer system and the administration on the ward of enalapril (for Jack's unrelated conditions). It was established at the trial that the administration of the enalapril may have contributed towards his death but did not cause it.

16. Nicol J directed the jury that the prosecution had to show that what Dr Bawa-Garba did or did not do was "truly exceptionally bad".

17. On 4 November 2015 Dr Bawa-Garba was convicted of gross negligence manslaughter. Ms Amaro was also convicted of the same offence and, in due course, was removed from the Register of Nurses and Midwives. Ms Taylor was acquitted.

18. On 14 December 2015 Dr Bawa-Garba was sentenced to a term of two years' imprisonment, suspended for two years. She was also ordered to pay £25,000 towards the costs of the prosecution. Nicol J's sentencing remarks, so far as relevant, were as follows:

> "There is no guideline [set by the Sentencing Guidelines Council] for gross negligence manslaughter. No case from the Court of Appeal has been identified as a guideline authority ... Inevitably the facts differ ... That said, it is of

course necessary to look carefully at the individual case to consider the nature of the offence, the culpability of the defendant and any mitigating features.

I directed the jury that they could convict if they were sure that your failures significantly contributed to Jack's death or led him to die significantly sooner than he would otherwise have done. I consider it right to pass sentence on the basis that it was the latter alternative of which the jury were satisfied here.

I take into account the circumstances in which your offences took place. The CAU of the LRI was a busy ward. It could not limit its intake. All children had to be seen, assessed and treated. There was no evidence that either of you neglected Jack because you were lazy or behaved for other selfish reasons. You both had other patients to attend to. The problem was that neither of you gave Jack the priority which this very sick boy deserved and in your case, Hadiza Bawa-Garba, you were falsely reassured by the apparent improvement in Jack's condition from the treatment which you did give him.

There was a limit to how far these issues could be explored in the trial, but there may be some force in the comment that yours was a responsibility that was shared with others.

I turn to the mitigation which has been extremely capably advanced by your counsel. Hadiza Bawa-Garba, you were 35 at the time of this offence. You had wished to become a doctor since the age of 13. Medicine was your vocation. As a result of this offence, your career as a doctor will be over.

I received numerous testimonials that spoke in graphic terms of your skill as a doctor, your dedication to your patients and the high regard in which your colleagues held you. You were two years away from completing your training and being able to apply for posts as a consultant. All that is over now. Like Isabel Amaro, you have no previous convictions.

Both of you have also had to wait some considerable time before these two proceedings have come to an end. I am told that in April 2012, the CPS wrote to both of you to say that you would not be prosecuted.

Both of your counsel accept that this offence is so serious that only a sentence of imprisonment will suffice. The real issues are what should be its length and whether it should be suspended. I have decided that in each case, the right length is two years. I've also decided that in light of all the circumstances of your offences and in the light of the mitigation I have heard, those sentences will be suspended."

19. On 29 November 2016 the Court of Appeal (Criminal Division) refused Dr Bawa-Garba leave to appeal against her conviction: *R v Bawa-Garba (Hadiza)* [2016] EWCA Crim 1841. Sir Brian Leveson P, giving the judgment of the court, said (at [36]):

> "... the judge had correctly directed the jury that the prosecution had to show that what a defendant did or did not do was 'truly exceptionally bad'. Suffice to say that this jury was (and all juries considering this offence, should be) left in no doubt as to the truly exceptional degree of negligence which must be established if it is to be made out".

The legislative context

The statutory framework

20. The legislation concerning disciplinary proceedings for medical professionals is contained in MA 1983 and in various statutory instruments made pursuant to that Act. The relevant statutory instruments in the present case are the General Medical Council (Constitution of Panels, Tribunals and Investigation Committee) Rules Order of Council 2015, pursuant to which Medical Practitioners Tribunals ("MPTs") are constituted, and the General Medical Council (Fitness to Practise) Rules Order of Council 2004 ("the Fitness to Practise Rules"), which governs the conduct of fitness to practise disciplinary proceedings before MPTs.

21. Section 1 of MA 1983 sets out the objectives of the GMC as follows:

> "(1A) The over-arching objective of the General Council in exercising their functions is the protection of the public.
>
> (1B) The pursuit by the General Council of their 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."

22. When it is alleged that a registered medical practitioner's fitness to practise is impaired by reason of a conviction for a criminal offence, resulting in the imposition of a custodial sentence, section 35C of MA 1983 and rule 5 of the Fitness to Practise Rules require the Registrar of the Investigative Committee of the GMC to refer the allegation to the Medical Practitioners Tribunal Service ("the MPTS") for it to be considered by a MPT:

23. Under 34(3) and (5) of the Fitness to Practise Rules a certificate of conviction produced before a Tribunal is conclusive evidence of the offence committed. They provide as follows:

> "(3) Production of a certificate purporting to be under the hand of a competent officer of a Court in the United Kingdom or overseas that a person has been convicted of a criminal offence or, in Scotland, an extract conviction, shall be conclusive evidence of the offence committed.
>
> ...
>
> (5) The only evidence which may be adduced by the practitioner in rebuttal of a conviction or determination certified in the manner specified in paragraph (3) or (4) is evidence for the purposes of proving that he is not the person referred to in the certificate or extract."

24. Where an allegation of impairment is referred to the MPTS for consideration by a MPT, the MPT is empowered by section 35D of MA 1983 to order various sanctions, including suspension of a person's registration in the Register or erasure for a minimum period of five years of that person's name from the Register.

The GMC's Sanctions Guidance

25. The GMC publishes "Sanctions Guidance" for use by MPTs when, among other things, considering what sanction to impose following a finding that a doctor's fitness to practise is impaired. It states that the main reason for imposing sanctions is to fulfil the statutory objectives in section 1 of MA 1983. It says the following about maintaining public confidence:

> "**Maintaining public confidence in the profession**
>
> 17. Patients must be able to trust doctors with their lives and health, so doctors must make sure that their conduct justifies their patients' trust in them and the public's trust in the profession ... Although the Tribunal should make sure the sanction it imposes is appropriate and proportionate, the reputation of the profession as a whole is more important than the interests of any individual doctor."

26. The Sanctions Guidance points out (at para 24) that mitigating factors carry less weight when the concern is about patient safety or is of a more serious nature "than if the concern is about public confidence in the profession". Mitigating factors include (at para 25): insight into the problem, remediation, adherence to good practice, past record, the circumstances leading to the incidents of concern such as lack of training or supervision, personal and professional matters such as work-related stress, and the lapse of time since an incident occurred. Having said (at para 31) that, when remediation is fully successful, a finding of impairment is unlikely, the Sanctions Guidance continues:

> "32. However, there are some cases where a doctor's failings are irremediable. This is because they are so serious or persistent that, despite steps subsequently taken, action is needed to maintain public confidence. This might include where a doctor knew, or ought to have known, they were causing harm to patients, and should have taken steps earlier to prevent this."

27. The following, among other things, is said in connection with suspension:

> "86. Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (ie for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession)."

28. Examples are given of when suspension may be appropriate, such as where there has been an acknowledgment of fault and the behaviour is unlikely to be repeated, or where there was deficient performance but there is evidence of insight and the potential for remediation, or where there is no evidence of the repetition of similar behaviour since the incident.

29. The following, among other things, is said about erasure:

> "102. Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor.
>
> 103. Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).
>
> (a) A particularly serious departure from the principles set out in [the document published by the GMC entitled] *Good Medical Practice* where the behaviour is fundamentally incompatible with being a doctor.
>
> (b) A deliberate or reckless disregard for the principles set out in *Good Medical Practice* and/or patient safety.
>
> (c) Doing serious harm to others (patients or otherwise), either deliberately or through incompetence and particularly where there is a continuing risk to patients (see further guidance below at paragraphs 123–126 regarding failure to provide an acceptable level of treatment or care) ..."

30. Other examples include violence and dishonesty.

31. Paras 123 and 126 state as follows:

> "**Failing to provide an acceptable level of treatment or care**

> 123. Cases in this category are those where a doctor has not acted in a patient's best interests and has failed to provide an adequate level of care, falling well below expected professional standards … Particularly where there is a deliberate or reckless disregard for patient safety or a breach of the fundamental duty of doctors to '*Make the care of [your] patients [your] first concern' (Good Medical Practice)*, paragraph 1).
>
> ...
>
> 126. However, there are some cases where a doctor's failings are irremediable. This is because they are so serious or persistent that, despite steps subsequently taken, action is needed to maintain public confidence. This might include where a doctor knew, or ought to have known, they were causing harm to a patient and should have taken steps earlier to prevent this."

The appeals process

32. Pursuant to section 40A of MA 1983, which came into force on 31 December 2015, the GMC may appeal the sanction ordered by a MPT to the High Court where the GMC considers that the decision is not sufficient for the protection of the public.

33. On such an appeal under that section, the court may dismiss the appeal, or allow the appeal and quash the relevant decision, or substitute for the relevant decision any other decision which could have been made by the MPT, or remit the case to the MPTS for them to arrange for a MPT to dispose of the case in accordance with the directions of the court,

34. Although it does not affect the present appeal, it should be noted that the Secretary of State for Health and Social Care announced on 11 June 2018 that the Government would support the recommendations of the Williams Review into gross negligence manslaughter in healthcare, including the recommendation that the GMC should lose its right to appeal against decisions of a MPT under section 40A: Professor Sir Norman Williams, *Gross negligence manslaughter in healthcare* (11 June 2018, https://www.gov.uk/government/publications/williams-review-into-gross-negligence-manslaughter-in-healthcare).

The disciplinary proceedings

The Tribunal's determination as to impairment

35. On 20 February 2017 the Tribunal was convened to determine whether, on the basis of Dr Bawa-Garba's conviction, her fitness to practise was impaired. There were three members of the Tribunal, comprising two lay members and a registered medical practitioner. The lay members were Mr Miran Uddin, who is legally qualified and chaired the panel, and Ms Elizabeth Daughters. The medical member was Mr Gulzar Mufti, who was a consultant urological surgeon. The Tribunal was supported by a legal assessor, Ms Judith Walker. The Tribunal heard evidence over the course of three days, from 20 February to 22 February, and heard oral evidence from two consultants, but not from Dr Bawa-Garba.

36. In its written determination dated 22 February 2017 ("the Impairment Decision") the Tribunal concluded that Dr Bawa-Garba's fitness to practise was impaired. The Tribunal found (at para 18) that she "fell far below the standards expected of a competent doctor at your level", had brought the profession into disrepute, and breached a fundamental tenet of the medical profession relating to good clinical care. It found (at para 19), however, that her clinical failings, serious as they were, were capable of being remedied and had been addressed. It also noted that two consultants described her as an excellent doctor. The Tribunal noted (at para 20) a submission on behalf of the GMC that her failings had come "out of the blue and for no apparent reason". The Tribunal accepted that she had remediated the specific clinical failings identified and had practised safely until November 2015. The Tribunal considered that the risk of her "suddenly and without explanation falling below the standards expected on any given day" were "no higher than for any other reasonably competent doctor". The Tribunal concluded, nevertheless, that a finding of impairment was required to maintain public confidence in the profession and to promote proper professional standards and conduct for members of the profession (at paras 21-23).

The Tribunal's determination as to sanction

37. The same Tribunal panel reconvened on 12 June 2017 to consider what sanction, if any, to impose. Over the course of two days, from 12 June 2017 to 13 June 2017, it heard further oral evidence, but not from Dr Bawa-Garba. On 13 June 2017 the Tribunal issued its decision ("the Sanction Decision") imposing the sanction of an immediate suspension for a period of 12 months. The suspension was subject to review but that review could not lead to an extension of the suspension unless it was concluded on review that Dr Bawa-Garda's fitness to practise remained impaired. The Tribunal rejected as disproportionate the GMC's contention that Dr Bawa-Garba's name should be erased from the Register.

38. The Tribunal said (at para 14) that, in reaching its decision on sanction, it had taken account of the Sanctions Guidance and also its findings in relation to impairment. The Tribunal said (at para 15) that it considered its overarching objective was to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for the medical profession. The Tribunal said (at para 16) that it had borne in mind that the sanctions were not to be punitive but to protect patients and the public interest. The Tribunal set out (at paras 18-19) mitigating and aggravating factors as follows (referring to Jack as "Patient A"):

> "Mitigating Factors
>
> 18. In mitigation the Tribunal had regard to the following factors:
>
> • Other than this matter, you have an unblemished record as a doctor
>
> • You were of good character prior to your offence
>
> • You remained employed by the Trust up until your conviction in 2015

> • There is no evidence of any concerns being raised regarding your clinical competency before or after your offence
>
> • The length of time which has passed since your offence
>
> • Before the events of 18 February 2011, you had recently returned from maternity leave and whilst you had completed some on-call shifts, this was your first shift in an acute setting
>
> • On the day in question, you were covering CAU, the emergency department and the ward
>
> • The multiple systemic failures identified in the Trust investigation following the events of 18 February 2011
>
> • There is no evidence to suggest that your actions on 18 February were deliberate or reckless.
>
> Aggravating Factors
>
> 19. The Tribunal balanced those mitigating factors against what it considered to be the aggravating factors in this case:
>
> • Patient A was vulnerable by reason of his age and disability
>
> • Your failings in relation to Patient A were numerous, continued over a period of hours and included your failure to reassess Patient A following your initial diagnosis or seek assistance from senior consultants
>
> • Even though you expressed your condolences to the family of Patient A, there is no evidence before this Tribunal that you subsequently apologised to them."

39. The Tribunal rejected imposing no sanction or merely imposing conditions on registration.

40. The Tribunal then considered (at paras 26-29) suspension, as follows:

> "26. The Tribunal was mindful that your actions marked a serious departure from Good Medical Practice, and contributed to Patient A's early death and which continues to cause great distress to Patient A's family.
>
> 27. It reminded itself of its findings in its determination on impairment, namely:
>
> • It was satisfied that you had remediated the deficiencies in your clinical skills and had practised safely for a period of almost four years; both Dr Barry and Dr Cusack described you as an excellent doctor.
>
> • It was satisfied that the risk of you putting a patient at unwarranted risk of harm in the future was low.

> • The basis of the Tribunal's finding on impairment was that public confidence in the profession and upholding of proper standards would be undermined if a finding of impairment were not made in your case.
>
> 28. The Tribunal had regard to the oral evidence of Dr Cusack, who stated that following the events of 18 February 2011, a Trust investigation was carried out which highlighted multiple systemic failures which existed at the time of these events. These included 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. The Tribunal therefore determined that 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.
>
> 29. The Tribunal was satisfied that the evidence of Dr Cusack was honest and reliable and that he could appropriately testify to your level of insight and remorse as he met with you regularly in a supervisory capacity. He initially met with you every 2 weeks and then subsequently up to your appearance in court in December 2015, aside from the period during which you were on your second period of maternity leave during 2012/13. It bore in mind that before and after the events leading to your conviction, you were considered by colleagues to be a good and competent doctor. It had regard to the various positive testimonials submitted by colleagues on your behalf. Following the incident, you continued to work at the Trust and were described as being in the top third of your Specialist Trainee cohort. The Tribunal accepted the evidence of Dr Cusack that you had reflected deeply and demonstrated significant and substantial insight in your conversations with him. However, the Tribunal was unable to conclude that you had complete insight into your actions as it did not hear from you directly."

41. The Tribunal then referred to *Bijl v General Medical Council* [2001] UKPC 42; [2002] Lloyd's Rep Med 60, in which Lord Hoffmann said (at [13]) that proper concern with public confidence in the profession and its procedures for dealing with "doctors who lapse from professional standards" 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".

42. The Tribunal concluded (at paras 31-32) as follows:

> "31. Further, the Tribunal was of the view that a fully informed and reasonable member of the public would view suspension as an appropriate sanction, given all the

> circumstances of your case. It was therefore satisfied that the goal of maintaining public confidence in the profession would satisfied by suspension of your registration.
>
> 32. The Tribunal also considered whether it would be appropriate to erase your name from the Medical Register. However, in the circumstances of the case, balancing the mitigating and aggravating factors, the Tribunal concluded that erasure would be disproportionate. In reaching this decision, it considered paras 101–105 and 126 of the Sanctions Guidance. In the judgement of the Tribunal, in all of the circumstances of this case, your actions and subsequent conviction are not fundamentally incompatible with continued registration. It also concluded that 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 as 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."

43. The Tribunal went on to say (at para 35) that a maximum period of 12 months was necessary for the completion of Dr Bawa-Garba's penal suspended sentence of imprisonment and to maintain public confidence in the profession and uphold proper standards. It also directed (at para 36) a review of the suspension order prior to its expiry because of the Tribunal's conclusion that Dr Bawa-Garba did not have complete insight and had been out of practice for a significant period of time.

The current proceedings

44. The GMC appealed the Sanction Decision pursuant to section 40A of MA 1983. It sought an order of the Divisional Court quashing the Tribunal's determination on sanction and substituting a direction of erasure from the Register.

45. The appeal was heard on 7 December 2017. The Divisional Court handed down its decision on 25 January 2018, allowing the GMC's appeal, quashing the decision of the Tribunal to suspend Dr Bawa-Garba's registration for a period of 12 months, and substituting in its place a direction that her name be erased from the Medical Register. The lead judgment was given by Ouseley J, with whom Gross LJ agreed.

Judgment under appeal

46. Ouseley J summarised (at [38]) his reasons for allowing the appeal as being that full respect ought to have been given by the Tribunal to the jury's verdict that Dr Bawa-Garba's failures on the day in question were truly exceptionally bad. The Tribunal's approach, however, did not respect the true force of the jury's verdict, nor did it give it the weight required when considering whether any sanction short of erasure could maintain public confidence in the profession and maintain its proper professional standards and conduct.

47. Ouseley J said (at [39]) that, whilst it is true and important that sanctions are protective not punitive and that the issue is not to be determined by expressions of opinion and demand for blame and punishment by the public, that scarcely advanced

the decision as to which sanction was necessary for maintaining public confidence in the profession and maintaining its proper professional standards and conduct. He said that the relevant tests for those public interests are now contained in *General Medical Council v Jagjivan* [2017] EWHC 1247, [2017] 1 WLR 4438, *Raschid v General Medical Council* [2007] EWCA Civ 46, [2007] 1 WLR 1460, and *Bolton v Law Society* [1994] 1 WLR 512.

48. Ouseley J rejected (at [40]) the GMC's submission that there is a presumption that a conviction for manslaughter by gross negligence should lead to erasure in the absence of exceptional or truly exceptional circumstances. He considered that the issue depends on the facts and circumstances of each case, considered individually, and it is unwise to circumscribe which factors are required or alternatively are of little weight.

49. Ouseley J went on to say (at [41]-[43]) that the Tribunal's decision was not consistent with, and did not respect, the verdict of the jury as it should have. He considered that the Tribunal reached its own and less severe view of the degree of Dr Bawa-Garba's personal culpability as a result of considering the systemic failings or failings of others and personal mitigation which had already been considered by the jury, and then coming to its own, albeit unstated, view that she was less culpable than the verdict of the jury established. Ouseley J held that the correct approach, enjoined by Rule 34 of the Fitness to Practise Rules, is that the certificate of conviction is conclusive not just of the fact of conviction; it is, he said, the basis of the jury's conviction, which must also be treated as conclusive. On that basis, he reasoned, although systemic failings or the failings of others may reduce Dr Bawa-Garba's culpability, they could not reduce her failures, which were her personal responsibility, below a level which the jury had found was truly exceptionally bad. The Tribunal had to, and failed to, recognise the gravity of the nature of the failings, on the basis of the jury's verdict, notwithstanding those systemic factors and the failings of others and personal mitigation. He said (at [44]) that the views expressed on behalf of Dr Bawa-Garba, by Dr Cusack and Dr Barry appeared at odds with evidence accepted at the trial. He added (at [45]) that there were two "systemic" failings not explored at trial, but that they could not have affected the verdict.

50. In particular, he noted (at [46]) that Dr Bawa-Garba's culpability, as reflected in the jury's verdict, was not reduced by the fact that, had systemic patient safety nets not failed, her serious failings would not have had such serious consequences as resulted. Furthermore, notwithstanding factors of personal mitigation, he considered (at [47]) that it followed from the verdict, by which the Tribunal was bound, that the failings were severe.

51. Ouseley J went on to note (at [48]-[49]) that, where erasure is indicated, as it was indicated here by the Sanctions Guidance at para 103(c) – doing serious harm to a patient through incompetence even where there is no continuing risk to patients – 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, given that this, rather than a continuing need for remediation, was the basis for the finding of impairment.

52. He accepted (at [50]) the Tribunal's conclusions on remediation, personal mitigation and the fact that other things went wrong that day. He said, however, that where a patient dies sooner than he would have done because of a series of failings over the

course of some hours for which the registrant has to take personal responsibility, findings which the Tribunal had to treat as truly exceptionally bad, it would require rather stronger circumstances than those present for suspension to be sufficient to maintain public confidence in that profession, and its procedures for maintaining its professional standards.

53. He said (at [52]) that the fact that Dr Bawa-Garba had addressed the specific failings that arose on the day in question, and that for many years afterwards she had practised safely and competently, were factors which would weigh with "a fully informed and reasonable member of the public". He concluded (at [53]), however, that the Tribunal did not give the weight required to the jury's verdict and was "simply wrong" to conclude that, in all the circumstances, public confidence in the profession and in its professional standards could be maintained by any sanction short of erasure. He said that the misconduct by gross negligence manslaughter in the present case involved a particularly serious departure from the principles outlined in Good Medical Practice, and the behaviour was fundamentally incompatible with being a doctor. It involved truly exceptionally bad failings, causing very serious harm to a patient.

54. Gross LJ agreed (at [55]) with Ouseley J that the Tribunal failed properly to reflect or respect the jury's conviction of Dr Bawa-Garba of manslaughter by gross negligence, from which it necessarily followed that her failings were "truly exceptionally bad". He agreed, therefore, that the Tribunal was wrong and that the appropriate sanction must be erasure rather than suspension.

The appeal to the Court of Appeal

Grounds of appeal

55. Dr Bawa-Garba was granted permission to appeal on five grounds by order of Simon LJ dated 23 March 2018. They are as follows:

> Ground 1: the Divisional Court erred by applying a presumption that a conviction of manslaughter by gross negligence should lead to erasure from the Medical Register save in exceptional circumstances.
>
> Ground 2: the Divisional Court erred by failing to appreciate the distinct roles of the jury in a criminal trial, on the one hand, and the MPT, on the other.
>
> Ground 3: the Divisional Court erred by unlawfully substituting its own judgment for that of the Tribunal, that the circumstances of the case were not sufficiently strong for suspension to be sufficient to maintain public confidence in the profession and its procedures for maintaining its professional standards.
>
> Ground 4: the Divisional Court erred in concluding that the Tribunal was precluded from taking into account the evidence of systemic failures occurring in the Hospital on 18 February 2011, as to do so would constitute a lack of respect for the jury's decision.
>
> Ground 5: the Divisional Court erred by reaching an irrational conclusion: no reasonable court could have concluded that erasure was the only sanction open to the Tribunal in the circumstances in order to maintain public

confidence in the profession and in its procedures for maintaining proper professional standards.

The interveners

56. By order dated 8 May 2018 Singh LJ granted permission for the British Medical Association ("the BMA") and the Professional Standards Authority for Health and Social Care ("the Professional Standards Authority") to intervene in this appeal by way of both written and oral submissions, given that the present appeal raises issues of wider importance, both for the medical profession and more generally. Neither organisation intervened in the Divisional Court proceedings.

57. The BMA is the trade union and professional association for doctors and medical students in the United Kingdom. At the beginning of 2018 it had approximately 156,000 members.

58. The Professional Standards Authority is the statutory body charged by Parliament under section 25 of the NHS Reform and Healthcare Professions Act 2002 with promoting the interests of patients and other members of the public in the performance by professional regulatory bodies in the sphere of health and social care of their statutory functions, and with formulating principles relating to good professional self-regulation.

59. By order dated 16 July 2018 the Master of the Rolls granted permission for the British Association of Physicians of Indian Origin to intervene by way of written submissions only. It is the largest membership organisation for Black and Minority Ethnic ("BME") doctors working in the NHS, and has extensive experience of the issues affecting BME doctors in the context of their access to registration, employment and professional regulation.

Discussion

60. The GMC's appeal from the Tribunal to the Divisional Court pursuant to section 40A of MA 1983 was by way of review and not re-hearing. In that respect, it differs from an appeal pursuant to section 40. Sub-paragraphs 19.1(1)(e) and (2) of Practice Direction 52D expressly state that appeals under section 40 are to be conducted by way of rehearing. Appeals pursuant to section 40A are governed by CPR 52.21(1), which provides that, subject to the exceptions mentioned there, appeals are limited to a review of the decision under appeal. That technical difference may not be significant. Whether the appeal from the MPT is pursuant to section 40 or section 40A, the task of the High Court is to determine whether the decision of the MPT is "wrong". In either case, the appeal court should, as a matter of practice, accord to the MPT the same respect: *Meadow v General Medical Council* [2006] EWCA Civ 1390, [2007] QB 462 at [126]-[128].

61. The decision of the Tribunal that suspension rather than erasure was an appropriate sanction for the failings of Dr Bawa-Garba, which led to her conviction for gross negligence manslaughter, was an evaluative decision based on many factors, a type of decision sometimes referred to as "a multi-factorial decision". This type of decision, a mixture of fact and law, has been described as "a kind of jury question" about which reasonable people may reasonably disagree: *Biogen Inc v Medeva Plc* [1997] RPC 1 at 45; *Pharmacia Corp v Merck & Co Inc* [2001] EWCA Civ 1610, [2002] RPC 41 at [153]; *Todd v Adams (t/a Trelawney Fishing Co) (The Maragetha Maria)* [2002] EWCA Civ 509, [2002] 2 Lloyd's Rep 293 at [129]; *Datec*

Electronics Holdings Ltd v United Parcels Service Ltd [2007] UKHL 23, [2007] 1 WLR 1325 at [46]. It has been repeatedly stated in cases at the highest level that there is limited scope for an appellate court to overturn such a decision. In *Biogen*, in which one of the issues raised by the defendant was whether the claimant's patent, which the claimant alleged had been infringed by the defendant, should be revoked as invalid because the patented invention was not original, Lord Hoffmann said (at [45]) as follows:

> "The question of whether an invention was obvious had been called "a kind of jury question" (see Jenkins L.J. in *Allmanna Svenska Elektriska A/B v. The Burntisland Shipbuilding Co. Ltd. (1952) 69 R.P.C. 63, 70*) and should be treated with appropriate respect by an appellate court. It is true that in *Benmax v. Austin Motor Co. Ltd.* [1955] A.C. 370 this House decided that, while the judge's findings of primary fact, particularly if founded upon an assessment of the credibility of witnesses, were virtually unassailable, an appellate court would be more ready to differ from the judge's evaluation of those facts by reference to some legal standard such as negligence or obviousness. In drawing this distinction, however, Viscount Simonds went on to observe, at page 374, that it was "subject only to the weight which should, as a matter of course, be given to the opinion of the learned judge". The need for appellate caution in reversing the judge's evaluation of the facts is based upon much more solid grounds than professional courtesy. It is because specific findings of fact, even by the most meticulous judge, are inherently an incomplete statement of the impression which was made upon him by the primary evidence. His expressed findings are always surrounded by a penumbra of imprecision as to emphasis, relative weight, minor qualification and nuance (*as Renan said, la vérité est dans une nuance*), of which time and language do not permit exact expression, but which may play an important part in the judge's overall evaluation. It would in my view be wrong to treat *Benmax* as authorising or requiring an appellate court to undertake a *de novo* evaluation of the facts in all cases in which no question of the credibility of witnesses is involved. Where the application of a legal standard such as negligence or obviousness involves no question of principle but is simply a matter of degree, an appellate court should be very cautious in differing from the judge's evaluation."

62. In *Assicurazioni Generali SpA v Arab Insurance Group (Practice Note)* [2002] EWCA Civ 1642, [2003] 1 WLR 577, Clarke LJ cited that passage (at [19]) and also said as follows:

> "15. In appeals against conclusions of primary fact the approach of an appellate court will depend upon the weight to be attached to the findings of the judge and that weight will depend upon the extent to which, as the trial judge, the judge has an advantage over the appellate court; the greater that advantage the more reluctant the appellate court should be to

> interfere. As I see it, that was the approach of the Court of Appeal on a "rehearing" under the Rules of the Supreme Court and should be its approach on a "review" under the Civil Procedure Rules 1998.
>
> 16. Some conclusions of fact are, however, not conclusions of primary fact of the kind to which I have just referred. They involve an assessment of a number of different factors which have to be weighed against each other. This is sometimes called an evaluation of the facts and is often a matter of degree upon which different judges can legitimately differ. Such cases may be closely analogous to the exercise of a discretion and, in my opinion, appellate courts should approach them in a similar way."

63. These paragraphs were approved by the House of Lords in *Datec* at [46]. In the recent case of *R (Bowen and Stanton) v Secretary of State for Justice* [2017] EWCA Civ 2181, McCombe LJ explained (at [65]) that, when the appeal is from a trial judge's multi-factorial decision, "the appeal court's approach will be conditioned by the extent to which the first instance judge had an advantage over the appeal court in reaching his/her decision. If such an advantage exists, then the appeal court will be more reticent in differing from the trial judge's evaluations and conclusions".

64. In *Bowen and Stanton*, McCombe LJ went on (at [67]) to quote from Lord Clarke's judgment in *Re B (A Child) (Care Proceedings)* [2013] UKSC 33; [2013] 1 WLR 1911 at [137] as follows:

> "In England and Wales the jurisdiction of the Court of Appeal is set out in CPR r 52.11(3) , which provides that 'the appeal court will allow an appeal where the decision of the lower court was (a) wrong; or (b) unjust because of a serious procedural or other irregularity in the proceedings in the lower court'. The rule does not require that the decision be 'plainly wrong'. However, the courts have traditionally required that the appeal court must hold that the judge was plainly wrong before it can interfere with his or her decision in a number of different classes of case. I referred to some of them in *Assicurazioni Generali SpA v Arab Insurance Group [2003] 1 WLR 577* ... at my paras 9–23. It seemed to me then and it seems to me now that the correct approach of an appellate court in a particular case may depend upon all the circumstances of that case. So, for example, it has traditionally been held that, absent an error of principle, the Court of Appeal will not interfere with the exercise of a discretion unless the judge was plainly wrong. On the other hand, where the process involves a consideration of a number of different factors, all will depend on the circumstances. As Hoffmann LJ put it in *In re Grayan Building Services Ltd (In Liquidation) [1995] Ch 241*, 254, 'generally speaking, the vaguer the standard and the greater the number of factors which the court has to weigh up in deciding whether or not the standards have been met, the more reluctant an appellate court will be to interfere with the trial judge's decision'."

65. McCombe LJ also quoted (at [71]) the case of *Smech Properties Ltd v Runnymede Borough Council* [2016] EWCA Civ 42, in which Sales LJ said as follows:

> "29. ... Where an appeal is to proceed, like this one, by way of a review of the judgment below rather than a re-hearing, it will often be appropriate for this court to give weight to the assessment of the facts made by the judge below, even where that assessment has been made on the basis of written evidence which is also available to this court. The weight to be given to the judge's own assessment will vary depending on the circumstances of each particular case, the nature of the finding or factual assessment which has been made and the nature and range of evidential materials bearing upon it. Often a judge will make a factual assessment by taking into account expressly or implicitly a range of written evidence and making an overall evaluation of what it shows. Even if this court might disagree if it approached the matter afresh for itself on a re-hearing, it does not follow that the judge lacked legitimate and proper grounds for making her own assessment and hence it does not follow that it can be said that her decision was "wrong"."

66. McCombe LJ commented on that passage as follows:

> "72. It seems to me that Sales LJ was addressing the exigencies of reviewing a first instance judge's assessment of primary facts, even where (as in our case) the evidence before the court below was entirely in writing. All will depend on the circumstances of the case and what opportunity the court has, in reality, to improve and correct the overall assessment of the evidence before the first instance judge as a whole."

67. That general caution applies with particular force in the case of a specialist adjudicative body, such as the Tribunal in the present case, which (depending on the matter in issue) usually has greater experience in the field in which it operates than the courts: see *Smech* at [30]; *Khan v General Pharmaceutical Council* [2016] UKSC 64, [2017] 1 WLR 169 at [36]; *Meadow* at [197]; and *Raschid v General Medical Council* [2007] EWCA Civ 46, [2007] 1 WLR 1460 at [18]-[20]. An appeal court should only interfere with such an evaluative decision if (1) there was an error of principle in carrying out the evaluation, or (2) for any other reason, the evaluation was wrong, that is to say it was an evaluative decision which fell outside the bounds of what the adjudicative body could properly and reasonably decide: *Biogen* at 45; *Todd* at [129]; *Designers Guild Ltd v Russell Williams (Textiles) Ltd (trading as Washington DC)* [2001] FSR 11 (HL) at [29]; *Buchanan v Alba Diagnostics Ltd* [2004] UKHL 5, [2004] RPC 34 at [31]. As the authorities show, the addition of "plainly" or "clearly" to the word "wrong" adds nothing in this context.

68. That was, indeed, the basis on which the Divisional Court in the present case allowed the appeal and substituted the sanction of erasure for the sanction of suspension. The error of principle identified by the Divisional Court was that the Tribunal did not respect the verdict of the jury, which found that the failings of Dr Bawa-Garba, in relation to the care and treatment of Jack, were "truly exceptionally bad". The Divisional Court considered that the Tribunal, having considered

systemic failings or failings of others and personal mitigation which had already been considered by the jury, came to its own, unstated, view that she was less culpable than the verdict of the jury established. The Divisional Court also considered that the only sanction properly and reasonably open to the Tribunal was erasure.

69. Grounds of appeal (2) and (4) attack the Divisional Court's decision on the point of principle. Grounds of appeal (1), (3) and (5) attack the Divisional Court's decision that erasure was the only sanction properly and reasonably open to the Tribunal.

70. The same criticisms of the Tribunal were maintained before us by Mr Ivan Hare QC, for the GMC. On the point of principle, he submitted that the Tribunal had reduced the level of Dr Bawa-Garba's culpability below that which had necessarily been found by the jury and established by her conviction, namely that her failings in her care and treatment of Jack were "truly exceptionally bad", which is the standard of care necessary for a conviction for gross negligence manslaughter: *R v Misra* [2004] EWCA Crim 2375*;* [2005] 1 Cr App R 21*; R v Sellu* [2016] EWCA Crim 1716, [2017] 4 WLR 64. He submitted that this was contrary to rule 34(3) of the Fitness to Practise Rules, which provides that production of a certificate under the hand of a competent officer of a court that a person has been convicted of a criminal offence "shall be conclusive evidence of the offence committed".

71. Mr Hare said that the Tribunal had attributed a lower level of culpability on the part of Dr Bawa-Garba than was necessarily established by her conviction for gross negligence manslaughter because it had wrongly taken into account, in her favour, systemic failings of the Trust and the failings of others. He submitted that it was wrong of the Tribunal to do so because most of them had been part of Dr Bawa-Garba's defence but had been regarded by the jury as insufficient to reduce her level of culpability below that required for a conviction for gross negligence manslaughter. He also submitted that they were, in any event, irrelevant.

72. Paragraph 28 of the Tribunal's Sanction Decision specified six matters which the Tribunal took into account as providing a "context of wider failings" than the failings of Dr Bawa-Garba alone. They were (1) failings on the part of the nurses and consultants, (2) medical and nursing staff shortages, (3) IT system failures which led to abnormal laboratory test results not being highlighted, (4) deficiencies in hand-over, (5) accessibility of the data at the bedside, and (6) the absence of a mechanism for an automatic consultant review. Mr Hare pointed out that the first four had been part of Dr Bawa-Garba's case at the trial. He said that matters (5) and (6) were of no consequence for the reasons given by the Divisional Court, namely that Dr Bawa-Garba could have called on a consultant and she had failed to use the data that she had.

73. Mr Hare emphasised in the course of his oral submissions that the GMC's case was not that such matters, and matters of personal mitigation, could never be taken into account by a MPT in deciding on impairment and sanction in the case of a medical practitioner convicted of gross negligence manslaughter. The GMC's position, he said, was that they could not reduce the culpability of Dr Bawa-Garba below that necessarily found by the jury in finding Dr Bawa-Garba guilty of that offence, namely truly exceptionally bad. He submitted that, furthermore, systemic failures on the part of the Trust were irrelevant to impairment and sanction because what was in issue in respect of those matters was the personal failings of Dr Bawa-Garba and not those of the Trust as an institution.

74. We reject the GMC's contention that the Tribunal made an error of principle in taking into account systemic failures on the part of the Trust and personal mitigation of Dr Bawa-Garba, even if they formed part of the evidence presented to the jury in support of Dr Bawa-Garba's defence in the criminal trial. In the first place, as was made clear in both the summing up and the sentencing remarks of Nicol J, systemic failures on the part of the Trust were only ever of peripheral relevance to the guilt or absence of guilt of Dr Bawa-Garba for gross negligence manslaughter. That issue turned on whether her own failings in the care and treatment of Jack were truly exceptionally bad, that is to say fell far below the standard expected of a reasonable doctor, and caused or contributed significantly to Jack's death. It is significant, in that regard, that both the prosecution and the defence agreed that the report commissioned by the Trust, following Jack's death, which investigated systemic failures on the part of the Trust and made recommendations for improvement, should not be placed before the jury. The centrality of Dr Bawa-Garba's personal acts and omissions in the jury's task of deciding on guilt was reflected in the directions of Nicol J to the jury, in which he said the following:

> "You may or may not think that the hospital itself was at fault, but you must set those feelings aside. Your role is not to choose between various people who may have played a part in Jack's death. It is not your job to decide whether these three defendants or any of them come top of that list or to try to rank them. Rather you must focus on the specific elements of manslaughter which the Crown must prove in relation to each of the defendants."

75. In his sentencing remarks, however, Nicol J said that, in determining the appropriate sentence, he did take into account the circumstances in which the offence had taken place. He mentioned that the unit was very busy and could not limit its intake, and that attention had been drawn to the deficiency of others, whose performance was less than ideal. He said:

> "There was a limit to how far these issues could be explored in the trial."

76. Secondly, there was a fundamental difference between the task and necessary approach of the jury, on the one hand, and that of the Tribunal, on the other. The task of the jury was to decide on the guilt or absence of guilt of Dr Bawa-Garba having regard to her past conduct. The task of the Tribunal, looking to the future, was to decide what sanction would most appropriately meet the statutory objective of protecting the public pursuant to the over-arching objectives in section 1(1A) and 1(B) of MA 1983, namely to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of the profession: *Bolton v Law Society* [1994] 1 WLR 512, at 518F-H; *Ziderman v General Dental Council* [1976] 1 WLR 330 at 333; *R (Redgrave) v Commissioner of Police of the Metropolis* [2003] EWCA Civ 4, [2003] 1 WLR 1136 at [38]. As Laws LJ said in *Raschid* (at [18]) the Tribunal is concerned with the reputation or standing of the profession rather than the punishment of the doctor; so did Sales J in *Yeong v General Medical Council* [2009] EWHC 1923 (Admin), [2010] 1 WLR 548 at [19] and [21]. As Ms Fenella Morris QC put it elegantly in her skeleton argument for the Professional Standards Authority, the decisions of the

Crown Court and the MPT are taken by different bodies, with different functions, addressing different questions and at different times.

77. Thirdly, different degrees of culpability are capable of satisfying the requirements of gross negligence manslaughter, some failings being more serious or even substantially more serious than others, even though they all constitute severe or gross negligence: *R v Garg* [2012] EWCA Crim 2520, [2013] 2 Cr App R (S) 30 at [47]. That is reflected in the different sentences available for a conviction for the offence of gross negligence manslaughter. In the present case the sentence passed by Nicol J of two years imprisonment suspended for two years was a conspicuously light sentence. In *R v Babamiri* [2015] EWCA Crim 2152 Lord Thomas LCJ said (at [37]) that an immediate custodial sentence of 12 months imprisonment was at the bottom end of the scale for gross negligence manslaughter. The sentence of Nicol J was even lighter than that. Nicol J said in his sentencing remarks that he passed sentence on the basis that the failures of Dr Bawa-Garba led Jack to die significantly sooner than he would otherwise have done, rather than that her failures had significantly contributed to his death; and he took into account all the circumstances in which the offences took place, including that her responsibilities for Jack's care and treatment were shared with others, as well as many points of personal mitigation. The Tribunal was just as much entitled to take into account, in determining the appropriate sanction, systemic failings on the part of the Trust, as part of the context for Jack's tragic death and Dr Bawa-Garba's role in it, as well as matters of personal mitigation, as Nicol J was entitled to do in determining the appropriate sentence for her crime: *R (Campbell) v Council v General Medical Council* [2005] EWCA Civ 250, [2005] 1 WLR 3488 at [19].

78. Fourthly, it follows that, in taking those matters into account in determining the appropriate sanction, the Tribunal was not disrespecting the verdict of the jury, as the Divisional Court thought. The Tribunal was not deciding that the failings of Dr Bawa-Garba were other than truly exceptionally bad. The Tribunal was conducting an evaluative exercise to determine what sanction was most appropriate to satisfy the statutory objective of protecting the public in the tripartite sense in section 1(1B) of MA 1983. Accordingly, the Tribunal's Sanction Decision was not contrary to Rule 34(3) of the Fitness to Practise Rules as the matters taken into account by the Tribunal in determining the sanction did not contradict any necessary findings of fact underpinning Dr Bawa-Garba's conviction.

79. Ouseley J in the Divisional Court appears to have thought that the Tribunal used language in its Sanction Decision which supports the inference that the Tribunal did not consider the conduct of Dr Bawa-Garba to be "truly exceptionally bad". He pointed in that context (at [43]) to the description of Dr Bawa-Garba's failings as falling "far short" of the standards expected. We do not accept that that inference can be drawn from the description used by the Tribunal of Dr Bawa-Garba's failings.

80. Nicol J said the following in his sentencing remarks:

> "I directed the jury that they could only convict you if they were satisfied that you were negligent and that your negligence significantly contributed to Jack's death or its timing. Furthermore, any such negligence had to be gross or severe. In other words, the jury had to be satisfied that what you did or didn't do was truly exceptionally bad. Your

> negligence had to be not just below the standard which could be expected of a reasonable doctor but far below that standard. By their verdict, the jury have shown that they were sure of all these matters."

81. The Tribunal plainly had in mind those words of Nicol J. In the Impairment Decision the Tribunal said (at para 8) that the jury was satisfied that Dr Bawa-Garba's negligence was "gross or severe", and (at para 18) that Dr Bawa-Garba's actions "fell far below the standards expected of a competent doctor at [her] level", and (at para 23) that Dr Bawa-Garba's actions "fell so far below the standards to be expected resulting in a criminal conviction". In the use of those descriptions, as in the reference in the Sanction Decision (at para 28) to Dr Bawa-Garba's actions "falling far short of the standards expected", the Tribunal was plainly reflecting the different ways in which Nicol J had himself described Dr Bawa-Garba's culpability in his sentencing remarks.

82. We turn, then, from the issue whether the Tribunal made an error of principle to the question whether the sanction of suspension for 12 months, subject to review prior to the end of the period of suspension, was a sanction properly and reasonably open to the Tribunal. In submitting that erasure was the only sanction properly open to the Tribunal, Mr Hare placed considerable weight on the Sanctions Guidance. At one point in his oral submissions, he suggested that the Sanctions Guidance had statutory force because it must have been published pursuant to section 35 of MA 1983. We reject that suggestion. Section 35 confers on the GMC power to provide advice for members of the medical profession on standards of professional conduct, standards of professional performance, and medical ethics. The Sanctions Guidance does none of those things. Its purpose is described on its first page as being:

> "… for use by medical practitioners tribunals, in cases that have been referred to the MPTS for a hearing, when considering what sanction to impose following a finding that the doctor's fitness to practise is impaired. It also contains guidance on the issue of warnings where a tribunal has concluded that the doctor's fitness to practise is not impaired. It outlines the purpose of sanctions and the factors to be considered."

83. The Sanctions Guidance contains very useful guidance to help provide consistency in approach and outcome in MPTs and should always be consulted by them but, at the end of the day, it is no more than that, non-statutory guidance, the relevance and application of which will always depend on the precise circumstances of the particular case: compare *Professional Standards Authority v Health and Care Professions Council* [2017] EWCA Civ 319 at [26].

84. Mr Hare submitted that the Sanctions Guidance indicated that erasure was the appropriate sanction in the present case. He referred to paragraph 17, which provides that, although the MPT should make sure the sanction it imposes is appropriate and proportionate, the reputation of the profession as a whole is more important than the interests of any individual doctor (which is based on Lord Bingham's statement to that effect in *Bolton* at 519E); paragraph 24, which states that the MPT is less able to take mitigating factors into account when the concern is about patient safety, or is of a more serious nature, than if the concern is about public confidence in the profession; and paragraph 32, which provides that there are some

cases where a doctor's failings are irremediable because they are so serious or persistent that, despite steps subsequently taken, action is needed to maintain public confidence, including where a doctor knew, or ought to have known, that they were causing harm to patients, and should have taken steps earlier to prevent this. He also laid particular weight on paragraph 103, which provides as follows, so far as relevant:

> "103. Any of the following factors being present may indicate erasure is appropriate … (c) Doing serious harm to others (patients or otherwise), either deliberately or through incompetence and particularly where there is a continuing risk to patients …"

85. We consider it is clear that none of those provisions necessarily required the sanction of erasure in the present case. What is an appropriate and proportionate sanction always depends on the facts of the particular case in question. Paragraph 103 makes that explicit with the word "may" in its first sentence, as well as the word "indicate", which is also permissive, not mandatory.

86. Mr Hare also referred to the apparent assumption of Nicol J in his sentencing remarks that the medical career of Dr Bawa-Garba was over. He referred to paragraph 111 of the Sanctions Guidance, which states that the sentence imposed is not necessarily a definitive guide to the seriousness of the offence, given that there may have been personal circumstances that led the court to be lenient, such as the expectation that the regulatory body would erase the doctor subsequent to the conviction and sentence. There was no indication in the sentencing remarks of Nicol J, however, that the assumption that Dr Bawa-Garba's medical career was at an end was what led him to impose an unusually lenient sentence. Furthermore, it would be quite wrong to suggest that his assumption should in some way have influenced the Tribunal to give effect to it through the sanction it ordered. Nor did the Divisional Court itself make any suggestion to that effect.

87. Undoubtedly, there are some cases where the facts are such that the most severe sanction, erasure, is the only proper and reasonable sanction. This is not one of them. Once it is understood that it was permissible for the Tribunal to take into account the full context of Jack's death, including the range of persons bearing responsibility for that tragedy and the systemic failings of the Trust, as well as the other matters relied upon by Dr Bawa-Garba, and that the Tribunal plainly had in mind its overriding obligation to protect the public for the future, in the tri-partite sense stated in section 1(1B) of MA 1983, it is impossible to say that the suspension sanction imposed by the Tribunal was not one properly open to it and that the only sanction properly and reasonably available was erasure.

88. In reaching its conclusion to the contrary, the Divisional Court appears to have adopted an impermissible approach, even though it was one which the Divisional Court itself expressly disclaimed: that erasure should be imposed if the medical practitioner has caused serious harm to a patient through incompetence, despite there being no continuing risk to patients, unless there are sufficiently significant reasons and circumstances for a lesser sanction consistent with the maintenance of public confidence in the profession and its professional standards. That amounts to a presumption of erasure in the case of such harm.

89. Ouseley J said (at [40]) that he did not accept the submission of Mr Hare (a submission which Mr Hare told us he never made and does not make) that there is a presumption that a conviction for manslaughter by gross negligence should lead to erasure in the absence of exceptional or truly exceptional circumstances. Ouseley J said that the then counsel for Dr Bawa-Garba was right that the issue depends on the facts and circumstances of each case, considered individually. For the reasons we have given, we entirely agree with those statements of Ouseley J.

90. The analysis of Ouseley J, however, leading to his decision that the appeal should be allowed and the sanction of erasure be substituted for suspension, has the effect of proceeding on precisely the approach which he had rejected as illegitimate. The steps in his analysis may be summarised as follows. First, Dr Bawa-Garba's conviction for gross negligence manslaughter meant that the jury had concluded that her personal culpability was "truly exceptionally bad" or gross or severe. Secondly, that view of the jury must be treated as conclusive. It was not open to the Tribunal to reduce Dr Bawa-Garba's level of personal culpability below "truly exceptionally bad". Thirdly, the jury found Dr Bawa-Garba guilty, notwithstanding systemic failings of the Trust or failings of others and personal mitigation. Accordingly, to treat them as reducing her culpability was not consistent with the verdict of the jury. Fourthly, compatibly with the indication of erasure at para. 103(c) of the Sanctions Guidance, where a patient dies sooner than he would have done because of a series of failings over the course of some hours for which the registrant has to take personal responsibility, and those are failings which the Tribunal had to treat as truly exceptionally bad, 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. Accordingly, fifthly, the culpability of Dr Bawa-Garba indicated by the jury's verdict was fundamentally incompatible with being a doctor since it involved truly exceptionally bad failings causing very serious harm to a patient.

91. It is clear from that analysis that Ouseley J approached the matter on the basis that (1) the gross negligence manslaughter verdict meant that the Tribunal had to accept that Dr Bawa-Garba's failings in her care and treatment of Jack had been truly exceptionally bad and had caused him very serious harm, (2) such culpability would require a sanction of erasure in order to maintain public confidence in the medical profession and its procedures for maintaining its professional standards unless there were sufficiently significant reasons for imposing a lesser sanction. That seems to us to be materially the same as a presumption that a conviction for manslaughter by gross negligence should lead to erasure in the absence of exceptional or truly exceptional circumstances, a proposition which Ouseley J rightly said (at [40]) was not correct.

92. As the Professional Standards Authority has emphasised, the present case is unusual. No concerns have ever been raised about the clinical competency of Dr Bawa-Garba, other than in relation to Jack's death. This is so even though she continued to be employed by the Trust until her conviction and for a significant part of that time carried out clinical work as a doctor. She was described before the Tribunal as being in the top third of her Specialist Trainee cohort. The Tribunal was satisfied that she had remedied the deficiencies in her clinical skills, and it accepted the evidence of two consultants that she is an excellent doctor. The Tribunal was satisfied that the risk of her putting a patient at unwarranted risk of harm in the future was low in the sense, as stated in the Impairment Decision, that the risk of her clinical practice suddenly and without explanation falling below the standards

expected on any given day is no higher than for any other reasonably competent doctor. The Tribunal also accepted the evidence that she was honest and reliable and had reflected deeply and demonstrated significant and substantial insight, even though it was unable to conclude that she had complete insight into her actions as it did not hear from her directly. It found that her deficient conduct in relation to the care and treatment of Jack was neither deliberate nor reckless and that she did not present a continuing risk to patients.

93. The Tribunal was an expert body entitled to reach all those conclusions. Indeed, none of them have been challenged by the GMC. The Tribunal was entitled to take into account, consistently with *Bijl v General Medical Council* [2001] UKPC 42, [2002] Lloyd's Rep Med 60 at [13], that an important factor weighing in favour of Dr Bawa-Garba is that she is a competent and useful doctor, who presents no material danger to the public, and can provide considerable useful future service to society.

94. As we said earlier in this judgment, the Tribunal was, in relation to all those matters and the carrying out of an evaluative judgement as to the appropriate sanction for maintaining public confidence in the profession, an expert panel, familiar with this type of adjudication and comprising a medical practitioner and two lay members, one of whom was legally qualified, all of whom were assisted by a legal assessor. As Lord Hope said in *Marinovich v General Medical Council* [2002] UKPC 36:

> "28. ... In the appellant's case the effect of the Committee's order is that his erasure is for life. But it has been said many times that the Professional Conduct Committee 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."

95. As Lord Wilson observed in *Khan* (at [36]), that is particularly true (as between the MPT and the courts) where the MPT's assessment of the effect on public confidence of misconduct relates to professional performance.

96. We see no conflict between that approach and the observation of Collins J in *Giele v General Medical Council* [2005] EWHC 2143 (Admin) [2006] 1 WLR 942 at [33] that public confidence in the profession must reflect the views of an informed and reasonable member of the public, or the statement of Holgate J in *Wallace v Secretary of State for Education* [2017] EWHC 109 (Admin), [2017] PTSR 675 (at [92] and [96(v)]) that public confidence in the profession must be assessed by reference to the standard of "the ordinary intelligent citizen" who appreciates the seriousness of the proposed sanction, as well as the other issues involved in the case.

97. Bearing in mind the respect due to such an expert body in reaching its evaluative judgment, there were no grounds for allowing the appeal under section 40A of MA 1983 on the basis that the Sanction Decision was wrong because the only sanction properly and reasonably open to the Tribunal was erasure.

Conclusion

98. For those reasons we allow this appeal, set aside the decision of the Divisional Court, restore the decision of the Tribunal and remit the matter to the Medical Practitioners Tribunal Service for review of Dr Bawa-Garba's suspension.