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NEWS

NEWS ANALYSIS

Back to blame: the Bawa-Garba case and the patient safety agenda

How can the NHS ever learn lessons from medical errors if doctors' personal reflections backfire in court, asks **Deborah Cohen**

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The BMJ

The case of Hadiza Bawa-Garba has left the UK medical profession rattled. Though there has been an outpouring of sympathy for the trainee paediatrician being pursued by the General Medical Council (GMC),[1] there is also an increasing sense that the case will leave the patient safety agenda in tatters by closing down any discussion of medical errors for fear of litigation.

Bawa-Garba's fate will be decided in the High Court on 7 December when the GMC attempts to overturn a decision by the Medical Practitioners Tribunal Service to keep her on the medical register. She was convicted of gross negligence manslaughter in 2015 after the death of 6 year old Jack Adcock from sepsis at Leicester Royal Infirmary.[2]

Blame culture

Senior and trainee doctors have told *The BMJ* that the handling of the case by those directly involved, the judiciary, and the GMC risks reviving a culture of blame in healthcare. "The criminalisation of medical error when events are considered singularly rather than as a part of a highly complex system is going to seriously impede learning," said Jonathan Cusack, the Leicester Royal Infirmary neonatologist who was Bawa-Garba's educational supervisor after the incident. He gave evidence in support of her in her criminal trial and at the medical practitioners tribunal.

David Grant, a consultant in paediatric intensive care at University Hospitals Bristol NHS Foundation Trust with a special interest in simulation and human factors, told *The BMJ* that the case risked setting a precedent that "will undermine all attempts to create a culture of openness and learning aimed at improving patient safety through proactive healthcare systems improvement."

He said, "Without such a system and culture in place, organisations and healthcare systems will continue to learn the same lessons over and over again, while patients continue to come to preventable harm."

Grant emphasised the need for people to be accountable for their errors, which can then "serve as triggers for systems analysis and organisational learning focused on preventing future occurrences."

Indeed, the report that resulted from the serious untoward incident review after Jack's death, seen by *The BMJ*, included recommendations to improve support for trainees and to enhance patients' safety. Though it criticised aspects of Bawa-Garba's involvement, it also found fault with "many aspects of the care that child JA received, and many of these were system failings."

Andrew Furlong, medical director at University Hospitals of Leicester NHS Trust, which runs Leicester Royal Infirmary, told *The BMJ* that the trust had "implemented a number of improvements to our systems and processes which have reduced the risk of such events occurring again."

He added, "This was a tragic event, and in 2015 a jury reached its decision having had all the evidence presented to it."

But the hospital's report was not heard in court. "Expert witnesses were stopped by prosecution barristers from discussing the significant improvements that the trust made after the incident which highlighted the multifactorial nature of the case," Cusack said.

Evidence from e-portfolio

What was fed into the trial, however, was a reflective document from Bawa-Garba's e-portfolio, which she filled in seven days after the incident.

Cusack has serious concerns about how a document intended for reflective practice and learning for personal development was used to apportion blame in the criminal justice process. He said, "The reflections in her e-portfolio show that at no point has she failed to admit her mistakes, which is critical if we are going to learn from tragic incidents and build a safety net to prevent them happening again."

The Royal College of Paediatrics and Child Health would not comment on the case but highlighted a statement from its consultation document sent to the Sentencing Council for England and Wales, which is reviewing its guidelines on manslaughter, including gross negligence manslaughter.[3] The college said that trainees were required to use their portfolios for personal reflection and subsequent learning. "However, we would be concerned if the duty of candour and educational reflection was wrongly influenced by court cases and convictions

of medical professionals for gross negligence manslaughter. This we believe would have a detrimental effect on the overall quality and safety of healthcare."

Other aspects of the investigation into Jack's death have also led to disquiet and anger among doctors in Leicester.

The BMJ has learnt that, five days after Jack's death, Bawa-Garba was asked to meet Stephen O'Riordan, the duty consultant at the time of the incident, in the hospital canteen. At the meeting she was asked to reflect on the circumstances and to sign a trainee encounter form setting out what she should have done differently. She was sent home immediately afterwards and told not to come back until she was asked to.

O'Riordan took the notes and typed them up. *The BMJ* has seen a copy of the form. It suggests that factors that let her down were her interpretation of biochemistry and venous blood gas results and her "lack of clear communication."

The BMJ understands that these were fed into the hospital's investigation.

O'Riordan left the trust a few months after the incident to take up a post at Cork University Hospital in Ireland.

Role of consultant

The court heard that O'Riordan was aware before Jack died that he had a serum pH of 7.084 and a blood lactate concentration of 11.4 mmol/L, which he wrote down in his notebook at evening handover. However, he did not perform a senior review of the boy because, he said, he was not specifically asked to by Bawa-Garba. He said he would have expected her to "stress" these results to him.

In his evidence to the practitioners tribunal Cusack said that although a trainee might not realise the full significance of this abnormal blood gas result, a consultant should. The role of a consultant is not just to review patients who are unwell but to recognise when a patient has been missed by junior members of the team. However, this role of the consultant was not discussed in the hospital investigation.

The BMJ asked O'Riordan to comment. A spokesperson for the Medical Defence Union responded on his behalf, saying that O'Riordan "cannot comment on the issues raised . . . because of his duty of patient confidentiality."

Nor did the hospital comment, when asked by *The BMJ*, on the appropriateness of how Bawa-Garba was asked to reflect on the incident by O'Riordan.

Grant said that although he did not want to comment on the specific details of the case, the Royal College of Paediatrics and Child Health's training standards required clinical supervision to ensure patients' safety. "It is the duty of senior members of the healthcare team to critically evaluate information provided by less experienced colleagues, identify incongruences, and reassess patients to better understand the clinical state of the patient," he said.

Jenny Vaughan, a neurologist who runs Manslaughter and Healthcare (www.manslaughterandhealthcare.org.uk), an online resource that follows prosecutions of healthcare staff in the criminal courts, has been watching Bawa-Garba's case.

"The GMC's actions here are purely punitive against a paediatrician who trusted the investigation process," she said. "It's terribly tragic that a child has died, but there are no winners in a system which 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."

Cusack, who was asked by trainees and the hospital trust to lead 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.

He added, "As an active educational supervisor I have seen a significant change in the way trainees reflect and document incidents.

"I've seen people behaving very defensively for understandable reasons, and trainers across the country are worried it's having an impact because it's such a high profile case."

The GMC acting in such a punitive way and focusing on retribution was only going to serve to make this situation worse, he added.

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Timeline: the Bawa-Garba case

- **February 2011—**6 year Jack Adcock dies from sepsis at Leicester Royal Infirmary
- **December 2014—**Bawa-Garda and two nurses are charged with gross negligence manslaughter[4]
- **November 2015**—Bawa-Garba is convicted of gross negligence manslaughter and given a two year suspended sentence[5 6]
- **August 2016**—The nurse also convicted in the case, Isabel Amaro, is struck off
- **December 2016**—Bawa-Garba is denied permission to appeal against her manslaughter conviction[7]
- **June 2017**—Medical practitioners tribunal suspends Bawa-Garba for 12 months, saying that "erasure would be disproportionate"
- **December 2017**—High Court to hear GMC's case to erase Bawa-Garba from the medical register