Analysis: The tragic cases of Jack Adcock, Dr HadizaBawa-Garba and Nurse Isabel Amaro: Contrasting consequences of criminalizing unintentional medical errors by the United Kingdom and New Zealand.

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Key messages

Patient safety may best be upheld by
- standardised process for investigation of medical error
- protection of employment rights and ability to reflect fully
- candid multidisciplinary discussions between patients and healthcare providers
- no fault accident and rehabilitation compensation schemes
Abstract

In November 2015, Dr HadizaBawa-Garba and agency nurse Isabel Amaro were convicted of manslaughter following the death of Jack Adcock, a six-year-old boy suffering from Group A Streptococcal (GAS) infection. We review this tragedy, which has global ramifications for personal culpability of professionals working in healthcare, from the perspectives of consultants from New Zealand (NZ) and the United Kingdom (UK). We explore the impact on National Health Service (NHS) practice, examine the consequences of criminalizing medical error on patient safety and investigate what the NHS might learn from other similar health care systems, such as NZ.
Introduction

The tragic case of Jack Adcock, has sent international shockwaves through the healthcare professions. Dr Bawa-Garba, a trainee doctor, and Agency Nurse Amaro were convicted of manslaughter by gross negligence, following the tragic death of six-year-old Jack Adcock, with Group A Streptococcal (GAS) disease. This case has set a precedent for health professionals to be held criminally liable for unintentional mistakes made when working in extremely challenging conditions.¹

While patient safety is paramount in both the UK National Health Service (NHS) and the New Zealand (NZ) District Health Boards (DHBs), there are important differences in legislation covering unintentional medical errors. ² ³ Auckland District Health Board (ADHB) accepts most unintentional medical errors are systemic rather than due to individual recklessness or negligence. ⁴ The governance structure allows concerns, by any member of staff, worried about patient care, to be investigated to determine how to improve processes. Once the “Datix Incident Management” system is activated, the error is escalated based on its severity. The management team is responsible for mitigating harm to patients and rectifying errors with the intention of improving systems safety and resilience. ⁴

Registered quality improvement activities such as reflections, case discussions and minutes of morbidity and mortality meetings have significant legislative protection in NZ. ³ The confidential information usually cannot be revealed beyond the process for which it was intended, although such protection is not absolute, in terms of criminal courts. Enhanced protection quality improvement activities could facilitate open disclosure of medical errors leading to improved patient safety.³ ⁴

We believe this case may have set back the patient safety agenda and have examined the healthcare systems in other countries to determine if there is a more effective way to manage complex medical errors, from which the NHS could learn.

Chronology of events

On Friday 18th February 2011, Jack Adcock, a six year old with Trisomy 21, on enalapril, following repair of an atrio-ventricular septal defect, was admitted with symptoms and signs of gastroenteritis and shock but was suffering from Group A Streptococcal (GAS) pneumonia. Dr Bawa-Garba, was a registrar on her first “on-call” day for paediatrics, at the University Hospitals of Leicester NHS Trust. She had recently returned from thirteen months of maternity leave but had not been provided with orientation to the Hospital.

There were medical staff shortages. Nursing numbers and skill mix did not reach nationally recommended standards of safety. ¹ ⁵ The laboratory information system (iLab) failed for the entire Hospital with results only available by telephone. There was no time for meal or bathroom breaks during the 13-hour shift.

There were errors and delays in Jack’s care. He was moved to the general paediatric wards around the time of evening handover. At 8 pm, approximately 45 minutes after receiving a dose of enalapril, Jack collapsed. Dr Bawa-Garba, one of 11 professionals who attended, but not the team leader, briefly
mistook Jack for another patient who had an agreed end of life plan. The resuscitation was interrupted for between 30 seconds and two minutes, not felt by expert witnesses to have affected the final outcome. Jack was pronounced dead at 9.20 pm.

The consultant responsible for the Children’s Assessment Unit (CAU), who was at a conference for most of the day, encouraged Dr Bawa-Garba to reflect on the case, in the hospital cafeteria, where he hand wrote and later typed these notes. Several reports indicate this confidential document informed the prosecution case.¹

The General Medical Council (GMC) confirmed that Dr Bawa-Garba bore no responsibility for the administration of the enalapril (p14 para IX) and that the consultant had overall responsibility for Jack’s care (p14 para V).⁶

The Hospital internal review identified multiple systemic failures with no single root cause for Jack’s death.⁷ In 2012, two weeks after the birth of her daughter, Dr Bawa-Garba was arrested and questioned under caution, but informed she would not be charged. In 2013, after fresh expert evidence, the coroner referred the case back to the UK Crown Prosecution Service (CPS) who brought charges of manslaughter by gross negligence against Dr Bawa-Garba, Nurse Amaro and Sister T.

In court, each defense barrister focused on the guilt of the other two defendants. Dr Bawa-Garba’s principal error was delay in diagnosing bacterial infection and prescribing antibiotics. The UK Chief Medical Officer in the same year acknowledged that "pendulum may have swung too far in advocacy of the need to reduce antibiotic use," but commented that most cases of gastroenteritis in young were likely viral.⁸

The court refused to hear particulars of improvements implemented by the Trust after the event, to aid understanding of the systems failures on the day. These details highlighted the full range of actions needed to reduce the risk of recurrence of such a tragedy. The court concluded that the contraindicated enalapril contributed to, but did not cause death.

In November 2015, after several days of deliberation, Dr Bawa-Garba was found guilty of gross negligence manslaughter by a majority verdict of 10:2. Nurse Amaro was found guilty and Sister T was acquitted. Dr Bawa-Garba’s relatives in Africa raised funds and met the Court fine. She unsuccessfully challenged her conviction in December 2016. Several online racist personal attacks were removed from the internet by the police.

On 13ᵗʰ June 2017, the Medical Practitioners Tribunal Service (MPTS) suspended Dr Bawa-Garba for a year, acknowledging the courts description of her as “before and after the tragic events ... a competent, above average doctor,”.¹² The GMC challenged the MPTS,¹ returning the case to the Court of Appeal. The Lord Justices upheld the appeal and Dr Bawa-Garba’s name was erased from the UK Medical register but she has been allowed a further challenge.

Many worldwide felt a grave injustice had occurred and raised funds to allow Dr Bawa-Garba to challenge her erasure and possibly her conviction.¹³
The British Medical Association (BMA) and the Royal Colleges united in supporting Dr Bawa-Garba, in discussions with the GMC. The Hon Jeremy Hunt former UK Health and Social Care Secretary tweeted his concerns about the impact of the GMC appeal on openness and transparency in the NHS. He ordered a rapid review of the area: the recently completed Williams inquiry, recommended robust and standardized investigation of gross negligence manslaughter and to revoke the right of the GMC to appeal future MPTS decisions.

**The Impact so far on Patient Safety**

Many doctors feel “there but for the grace of God go I.” One junior doctor comments “If we live in fear of being scapegoated by the system, by being thrown under the bus by our seniors and by personal reflective practice incriminating us, then we will practice defensively and we will not openly discuss failings to learn”. One online survey suggested that up to two thirds of doctors are less likely to disclose errors as a direct result of this case. In another, 52% of 682 GPs said they had now “stopped or adapted” their reflections.

The potential to discourage open disclosure of errors or suboptimal treatment, at personal through to organisational levels, could lead ultimately to less safe care

**The NZ medico legal perspective.**

The Medical Council of New Zealand (MCNZ) and the Health and Disability Commissioner (HDC), have broad statutory discretion for investigating and disciplining doctors accused of incompetence or negligence. It is likely that the HDC and MCNZ, like the MPTS, would give weight to the complexity, mitigating factors, and uncertainties, particularly the role of enalapril, in their judgements.

Manslaughter by gross negligence is a statutory offence under the Crimes Act 1961. However, since the amendment of the NZ law in 1997 from a simple negligence threshold to the major departure test (s150A of the Crimes Act) for a manslaughter conviction for breach of the legal duties in ss155 or 156 of the Crimes Act, there has been no conviction of a health professional for manslaughter in NZ.

It appears criminal prosecution in the absence of ill intent is viewed as purposeless in most cases. There was no ill intent in Dr Bawa-Garba’s actions. Professor Ron Paterson, former NZ Health and Disability Commissioner states “Prosecution has a limited part to play in accountability for unintended patient harm, and rehabilitation is an important goal in addressing the shortcomings of individual practitioners”.

NZ has a taxpayer funded no-fault Accident Compensation and Rehabilitation (ACC) scheme (1974) covering treatment injury. It offers a range of benefits including rehabilitation of injured persons and funding for retraining. ACC is required to assess all treatment injury claims for risk of harm and notify relevant authorities where there may be a potential risk to the public, which assists in reducing the incidence of injury from treatment. While the ACC does not afford medical practitioners immunity from criminal proceedings, the public generally accept that ‘doctors cannot be sued’ for negligence.
through this scheme, although a plaintiff could bring a claim for exemplary damage arising from personal injury.

The NZ industrial relations perspectives

NZ enjoys collegial relationships between senior and junior medical staff. Unacceptable hierarchical behaviour, harassment, bullying does occur but is censured. It has strict Health and Safety laws. Employers risk prosecution if they fail to provide a safe working environment with adequate meal and rest breaks. It is unlikely Dr Bawa-Garbay would have been permitted to work a thirteen-hour shift with no breaks for meals or rest.

The New Zealand Resident Doctors’ Association (NZRDA), which represents trainees, perspective is that strong medical unions with robust contractual protections are the best bulwark against unsafe hospitals. The collective agreement with DHBs ensures that providing cross-cover for colleagues is voluntary and only where the resident is confident in their ability to provide adequate of care. However the NZRDA has asked members to consider whether there are some situations when cross-cover is inappropriate, whether clinical orientation is sufficient, and to address situations where there is a reluctance to ask for consultant assistance.

When asked about the case, the NZ hospital consultants union responded, “The Association of Salaried Medical Specialists (ASMS) strongly supports New Zealand’s approach to unintentional medical error.”

How can we learn from these tragedies to improve patient safety?

These devastating events have important implications for patient safety. The multiple systems and human factors caused the holes in the Swiss cheese model to align. Opportunities for healthcare providers to learn from and to rectify systems errors are lost when one or two junior individuals are held criminally liable for errors when practicing in the overstretched, under-resourced NHS. Doctors recognize that the public must be protected from negligence but have called for a just culture to address unintentional errors, as in NZ.

Whether the adversarial nature of a criminal court allows a lay jury to weigh appropriately the individual, team, systemic contributions along with the weight of scientific evidence in an area as complex as healthcare, is a question which has been asked by many. Criminalizing inadvertent medical errors has potentially far reaching and chilling implications. Doctors have worried about the personal dangers involved in recording reflective practice with serious concern that there may be less open about discussion of potential mistakes. The Williams Review will go some way to allaying fears about an unjust process.

Patients are best served by candour and accountability, especially when there is uncertainty about the best treatment option. Defensive medicine could lead to iatrogenic complications from overtreatment. Sensible investigation and reasonable compensation schemes for unintentional error, as occurs in NZ may decrease the need for litigation. The National Patient Safety Agency (NPSA) has similarly recommended an open culture of reporting errors. If mistakes or suboptimal treatments are not
disclosed, they are likely to be repeated leading to erosion of public confidence in the medical profession.

Robust protection of trainee rights, as in NZ, enhances staff morale leading to good working practice. Healthcare professionals work in multi-disciplinary multi-ethnic teams from many backgrounds. International trainees have expressed fears regarding UK public perception of black or minority ethnic (BME) doctors, who are more likely to be sanctioned by the GMC. UK recruitment for high risk specialties, such as paediatrics, already vulnerable after Brexit, may worsen due to fear of racial discrimination and criminalization of error. Consequent declining staffing levels make serious errors more likely, such that the regulatory actions paradoxically decrease patient safety.

The role of managers and directors within organizations needs clarification with clear lines of responsibility for provision of safe healthcare with adequate resources. If healthcare cannot be safely provided, transparency and public accountability is required, acknowledging the complexity of the relevant issues.

The Trust report indicated multiple factors contributed to Jack’s death but did not address broader requirements for a leadership safety culture or more robust plans to recognise and mitigate IT failures. Prosecuting frontline junior clinical staff for unintentional errors, made within the context of unsafe systems, for which they have no responsibility or influence, will further compromise patient safety. International learning, rather than criminalization of unintentional medical errors should be the legacy of Jack Adcock’s tragic death.

Acknowledgements

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Conflicts of Interest

RA: the NZ perspective is through the lens of unintentional error and does not address other challenges faced by the NZ health system such as inequitable access to health care. JC is a supervisor for Dr Bawa-Garba and has supported her throughout the criminal and regulatory process. JV is a medical manslaughter expert and member of Team Hadiza. HK was co-author of a blog used by Team Hadiza to fundraise for independent legal support.
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