Position of University Hospitals of Leicester NHS Trust

in relation to Dr Hadiza Bawa-Garba

There has been a great deal of concern expressed in the medical press and by professional bodies such as the Royal Colleges as to the implications of the recent decision by the High Court to uphold an appeal by the General Medical Council (GMC) to erase Dr Hadiza Bawa-Garba from the medical register following her conviction for Gross Negligence Manslaughter in November 2015.

Dr Bawa-Garba was a doctor in training at Leicester when she was involved in the treatment of Jack Adcock, a six-year old child who tragically died whilst in our care in February 2011. There has been much speculation and comment on social media in relation to University Hospitals of Leicester NHS Trust (the Trust) and in particular as to what level of support was offered to Dr Bawa-Garba subsequent to Jack's death leading up to her conviction for Gross Negligence Manslaughter at Nottingham Crown Court in 2015.

We feel that it is important to set the record straight in terms the support provided by the Trust to staff both then and now.

Jack's death was reported to the Coroner immediately and she took the decision to instruct the police to investigate the death on her behalf.

The Trust initiated a Serious Untoward Incident investigation which identified a number of failings. The report made recommendations in response to the lessons learned from the investigation which included:

- ensuring better systems for induction and re-orientation of staff returning to work following prolonged periods of leave or absence
- improving visual aid prompts to alert staff of abnormal blood parameters
- increasing direct consultant supervision and presence on the Children's Assessment Unit
- improving handover tools and documentation
- improving prompts to remind staff to escalate concerns
- increasing pharmacy presence on the Children's Assessment Unit
- further work to develop a 'single front door' for the Children's Hospital (for GP-referred, ambulance and walk-in arrivals)

All of these recommendations and actions were accepted by the Trust in full, were acted on at the time and have been embedded.

Dr Bawa-Garba was provided with immediate support by the Trust and that level of support was discussed and agreed with Health Education East Midlands.

As part of the Coroner's investigation into Jack's death both medical and nursing experts were instructed. Both expert witnesses were highly critical of the care Jack received and of individuals involved in that care. As a result, the police arrested Dr Bawa-Garba in February 2012 on suspicion of Gross Negligence Manslaughter and conducted an interview under caution. Dr Bawa-Garba was bailed awaiting the decision of the Crown Prosecution Service (CPS).

At this stage, as is the Trust's statutory obligation in such circumstances, the Trust wrote to the GMC to advise of Dr Bawa-Garba's arrest.

The CPS subsequently took the view that there was not sufficient evidence to bring any criminal charges. Jack's parents requested a review of this decision and after several months' consideration, the CPS decision at the end of 2012 was that no criminal charges were to be brought against any member of staff.

The Coroner was therefore able to progress Jack's case to inquest noting the CPS' decision that no criminal charges were to be brought.

Dr Bawa-Garba remained at work with the Trust throughout. The Trust continued to provide her with direct consultant support in light of the various investigations taking place.

The Coroner listed the inquest for seven days commencing in July 2013. The Trust and all of the clinical staff criticised in the expert reports had independent legal representation for the inquest.

On the fifth day of the inquest, in her questioning of the medical expert witness, the Coroner asked him about the preventability of the cardiac arrest. In response to this line of questioning, the expert indicated that he was satisfied that the cardiac arrest was *preventable beyond reasonable doubt*.

In view of this development, the Coroner adjourned the hearing and the police reopened their investigation.

In July 2014 a further case file, including a new expert witness report, was presented by the police to the CPS for their consideration. The CPS appointed a QC to review the case and in December 2014, the CPS took the decision that Dr Bawa-Garba, the Children's Assessment Unit sister and an agency nurse were all to be charged with Gross Negligence Manslaughter.

At the point that Dr Bawa-Garba was charged, the GMC suspended her licence and the Trust were required to take her off patient facing duties. However, she continued to work within the Trust and to receive direct consultant support.

Following application to the High Court, Dr Bawa-Garba's GMC interim order of suspension was lifted and in May 2015 both the Trust and the consultant supporting her were

encouraging of a limited return to clinical duties provided that all patient contact was directly supervised by a consultant.

In November 2015, Dr Bawa-Garba was convicted of Gross Negligence Manslaughter and the GMC Interim Orders Panel amended her conditions of licence to a suspension meaning that she could no longer undertake clinical duties.

Dr Bawa-Garba's contract of employment with the Trust ran out at the end of November 2015 and was unable to be renewed in view of her conviction and suspension of licence to practice.

We would like to stress that Consultant supervisors and members of the Children's Hospital provided pastoral support to Dr Bawa-Garba in the months following Jack's death and during her subsequent criminal trial (and a number of our consultants continue to provide her with ongoing pastoral support).

There has been an ongoing programme of quality & safety improvements within the Trust and the Children's Hospital since 2011 with notable examples including:

- Increasing the number of dedicated consultants present and the levels of consultant supervision in the Children's Emergency Department and Assessment Units
- Introduction of Nervecentre – an electronic handover & task allocation system
- Introduction of electronic observations with automated alerts
- Near patient testing in the Children's ED with blood results available within 1 hour
- Improved handover documentation between the Children's ED & Assessment Unit
- Introduction of Adult & Paediatric Sepsis pathways with planned imminent roll-out of automated red-flag sepsis alerts via Nervecentre
- Sepsis boxes on all resuscitation trollies
- Regular safety huddles between senior clinicians & managers in the Children's Hospital at defined points throughout the day
- Strengthened guidance to junior doctors about how to raise safety concerns including introduction of a Junior Doctor's Gripes Tool for less urgent concerns

The Trust has met with our Doctors in Training Committee, our Clinical Senate, representatives of the East Midlands South paediatric trainees and held a series of meetings across all 3 of our sites with doctors of all grades in order to listen to and discuss their concerns concerning the recent High Court decision. We have stressed the importance of clinicians feeling able to raise concerns and made it clear that we will ***always support*** clinicians in doing so. Further guidance on this matter has been issued to all staff and we will continue to raise this through our regular forums with doctors in training.

We would also like to make it known that our Concerns, Conduct, Capability, Ill Health & Appeals Policy & Procedures for Medical Practitioners makes it clear that for Doctors in Training:

- the Trust and Health Education East Midlands will ensure joint cooperation and agreement in the management and support of issues relating to the conduct, capability or health of a practitioner
- concerns about the capability of practitioners in training grades should be considered initially as training issues with the Educational Supervisor and through the Director of Medical Education; the Postgraduate Dean should be informed from the outset.

Furthermore, it now our practice to invite a member of the Doctors in Training Committee to join the investigation panel when undertaking a Serious Incident investigation where doctors in training are involved.

In addition to the above and in conjunction with our Chief Registrars, the Doctors in Training Committee and the Department of Medical Education, we have recently undertaken a survey of all of our junior medical staff and are using the results of this to inform a Listening into Action project co-sponsored by our Chief Executive & Medical Director to improve the educational experience and working lives of junior doctors working in Leicester's Hospitals.

We as a Trust and clinical community take patient safety and staffing concerns very seriously and are committed to supporting all our clinicians to deliver the best care they can 7 days a week – one example of how we do this includes reviewing staffing levels across our 3 sites 4 times a day in our Operational Command Meetings chaired by a Senior Manager with the Director on Call and representatives from all of our clinical groups present.

We continue to work closely with clinicians, our Clinical Senate, doctors in training and Medical Education teams seeking to foster a culture where we learn from our mistakes and are open to suggestions from our patients, staff and the public to improve our systems and processes.

University Hospitals of Leicester NHS Trust April 2018