# ARDL

ASSOCIATION OF REGULATORY & DISCIPLINARY LAWYERS

QUARTERLY BULLETIN – WINTER 2019

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## Chairman's Introduction

Welcome to the Winter 2019 Edition of the ARDL Quarterly Bulletin. The bulletin starts with the sad news of the death of Rod Fletcher who was a founder member of ARDL and an important part of the administration and running of ARDL for many years. Rod was hugely respected in the regulatory world and ARDL owes him a debt of gratitude.

Our Bulletin also contains the Marion Simmons QC Prize winner essay as well as a very interesting article from Kenneth Hamer on the implications of Bawa-Garba.

**Iain Miller**
Kingsley Napley LLP

## Rod Fletcher

Rod Fletcher, founding member of ARDL, died on 6th November 2019. A much loved friend and respected lawyer, he will be sorely missed.

Rod graduated from Birmingham University in 1978. He qualified at the prestigious Kingsley Napley, joining Russell Jones & Walker in 1983 to set up a brand new criminal department. He was made partner in 1985. He initially established a strong team handling criminal and disciplinary cases for the Police Federation. His successful defences in 1996 and 1999 of the first two police firearms officers prosecuted in England and Wales for murder over the shootings of David Ewin in

Barnes and James Ashley in Brighton established his position as the pre-eminent lawyer in this field.

He then developed a strong team in fraud and regulatory work. His CV of cases is second to none. The Mirror Group - Maxwell case where he was first to test the SFO's section 2 powers in the Administrative Court, LIBOR, Barings, Bute Mining, Balfour Beatty and the Hatfield train derailment. He was instrumental in achieving the first ever civil fraud recovery order saving his client from criminal prosecution.

His public inquiry expertise included the Arms to Iraq Scott Inquiry, the Stephen Lawrence Inquiry and the Bloody Sunday Inquiry.

He was co-chair of the Criminal Law Committee of the International Bar Association and a founding member of ARDL, establishing networking opportunities that most lawyers in this field have enjoyed over many years.

Shortly after RJW was taken over by Slater and Gordon, Rod took on a new challenge by joining Herbert Smith Freehill in 2013. He attracted significant high profile cases to the firm, including the Barclays case notwithstanding his then recent diagnosis of cancer.

Always at the top of the legal rankings, Rod combined drive, ambition and leadership with modesty, humility and generosity, a hugely personable and much loved colleague.

Rod is survived by his wife Linda and step sons Jonathan and Kelvin.

**Scott Ingram**
Slater and Gordon

## Marion Simmons QC Essay – Extinction Rebellion: Perspectives on Public Engagement in Environmental Regulation

Environmental law, now a far-reaching body of regulation with deep impacts on individual and commercial life, had surprisingly humble beginnings. With origins in public law and the tort of nuisance, the twentieth century "regulatory turn"[1] saw disputes over troublesome neighbours slowly develop into scientific and systematic environmental controls. But while this progression met a genuine need for detailed, pre-emptive regulation, it also saw bureaucratic, top-down decision-making replace a process that had largely been driven by the public. Indeed, literature on regulatory law acknowledges the increasingly administrative character of regulation and the adverse impact this has on ensuring that decision-making is democratic.[2] This disconnect points to a key question within environmental law: does the public still have a role to play in determining regulatory standards? How should the rights of individuals be balanced with those of the public as a whole? And how might public engagement look in practice?

**Extinction Rebellion and Deliberative Democracy**

In April 2019, protests in London against the government's environment policy gave these questions a very public platform. The demonstrations attracted international media coverage, saw speeches by Greta Thunberg and Noam Chomsky, and prompted more than 1,000 arrests.[3] For its members, Extinction Rebellion represented not only a drive to raise protection standards, but also a broader dissatisfaction with the lack of public participation in environmental agenda-setting; a feeling that regulation was both ineffective and unrepresentative.[4]

The group's demands were clear: for Government to (1) declare a "climate and ecological emergency"; (2) commit to "reduce greenhouse gas emissions to net zero by 2025"; and (3) "be led by the decisions of a Citizens' Assembly on climate change and ecological justice".[5]

While the government did subsequently declare a climate emergency, this did not include specific policy positions, and the movement's suggested emissions targets were quickly dismissed by the Energy Transitions Committee as unworkable.[6] However, the third demand – which the government has yet to address – is fundamentally different in type; the call for a Citizens' Assembly is not a demand to change standards, but to change how standards are set. As such, it bears directly on the question of public participation in regulatory decision-making.

[1] Scotford, 'The Symbiosis of Property and Environmental Law', 1012

[2] Black, 'Proceduralising Regulation: Part I', 615.
[3] Wills, 'Extinction Rebellion's "Closing Ceremony"'
[4] Extinction Rebellion, <rebellion.earth/the-truth/demands/>
[5] Ibid
[6] McKie, 'Slow Burn? The Long Road to a Zero-Emissions UK'

Central to Citizens' Assemblies is the concept of deliberative democracy. While liberal democracy (in the Hobbesian sense) embraces collective action, it does so through private and individualised decision-making; each person determines which option suits their interests and the option with the most votes is accepted as the solution for the whole.[7] Under deliberative democracy, however, decision-making is made public; citizens work collectively to make "informed value judgments through debate and discussion".[8] Deliberation is used not only to determine the solutions, but also to shape the questions.[9] For Arnstein – whose seminal work in this area arranges modes of participation into a hierarchical 'ladder' – deliberative democracy is the first model in which the public can affect genuine change; it is a true "Partnership". Liberal democracy appears several rungs lower, under "Tokenism". As Arnstein explains, "there is a critical difference between going through the empty ritual of participation and having real power to affect the outcome of the process".[10]

Turning to practical examples, it is easy to see how Citizens' Assemblies caught the imagination of the Extinction Rebellion movement. Through the 1990s, the Public Utility Commission of Texas discuss electricity utilities using deliberative models. Contrary to expectations, the group decided to favour long-term sustainability over more immediate reductions in price.[11] A similar initiative is currently running in Poland to examine flood mitigation issues[12] and, beyond environmental concerns, Citizens' Assemblies have been established to discuss electoral reform in Canada and the Netherlands.[13] It remains unclear, however, whether Extinction Rebellion is motivated by Citizens' Assemblies as a democratic model or by the types of results they have historically achieved.

Realising deliberative democracy has, however, proven difficult. In addition to the substantial costs involved, 'deliberative' initiatives frequently compromise on theory to meet practical demands. Most often, a group debates issues 'deliberatively', but ultimately casts votes on pre-selected topics, as was the case in the example from Texas.[14] Similar (though, admittedly, not ostensibly 'deliberative') community engagement projects in Liverpool and North Wales assessing the viability of wind farms followed the same debate-and-vote system.[15] The result offers little additional benefit above conventional liberal democracy. As Lee warns, the effect is a sense of "hollowness in participatory exercises for major projects",[16] or, in Arnstein's words, the process becomes an elaborate "window-dressing ritual".[17]

Beyond practical challenges, the issue itself is also significant. In the above examples, none of the issues approaches the scale and complexity of setting regulatory thresholds as part of a national environment policy. In his study of the Montreal and Kyoto Protocols, Cole explains how – despite climate change being "the quintessential global-scale collective action problem" – both initiatives failed due to the sheer number of players and the disparities in each party's perceived costs and benefits. In essence, where India or Mexico were expected to cut back, the Germany or Sweden were not prepared to pay.[18] Albeit on a smaller scale, the same can be argued for national-level agenda-setting. Even if a deliberative democratic model could be realised in practice, its application is likely to be limited greatly in the types of issues it can address. Questions around local planning, electoral reform, or even tax brackets might be viable options, as the restricted remit offers a more conceptually certain starting point for discussion. However, environmental regulation is likely too multi-faceted an issue to be amenable to the deliberative process.

**Back to the Future: A Return to Public Law and Nuisance**

However, Extinction Rebellion may, albeit inadvertently, have raised an alternative solution. Simply by its presence – a small but coherent group challenging authority to protest its rights – it raises the possibility that interaction might not need to be deliberative, but contentious. The public may not need to be asked, but could instead assert their rights before the courts. As such, the following section explores avenues for public engagement through the courts, focusing less on revolutionising environmental regulation and more on the legal principles that helped to establish it.

[7] Black, 608
[8] Woolley, 'Trouble on the Horizon' 237
[9] Steele, 'Deliberation in Environmental Law' 423
[10] Arnstein, 'A Ladder of Citizen Participation' 217
[11] Herbick 'The Promise of Deliberative Democracy'
[12] Gazivoda, 'Making Democracy Work Again in Gdansk'
[13] Fournier, 'When Citizens Decide' 5
[14] Fishkin, 'When the People Speak Deliberately' 111
[15] Armeni, 'Planning and Community Benefits' 433
[16] Lee, 'Public Participation and Climate Change' 61
[17] Arnstein, 219
[18] Cole, 'Climate Change and Collective Action' 23

Here, there are two possible routes. The first is to challenge decision-making through judicial review. In England and Wales, administrative decisions may be challenged not only on the common-law grounds famously set out in CCSU v Minister for the Civil Service,[19] but under European Union requirements to "take all appropriate measures, whether general or particular, to ensure fulfilment of [Treaty] obligations"[20] – a principle which has since been aligned explicitly with environmental decisions.[21] A number of cases serve to illustrate this point. In Berkeley v Secretary of State for the Environment, a member of the public successfully challenge the construction of a football stadium, as administrators had failed to adequately consider an Environmental Impact Assessment.[22] Similar grounds were also used for the widely-reported United States case Massachusetts v. Environmental Protection Agency, in which the Supreme Court found that 'scientific uncertainty' did not constitute sufficient reasoning for the EPA's decision not to regulate carbon emissions.[23]

Especially important are requirements for public consultation and, again, significant protection is provided under EU law. The EU's Strategic Environment Assessment Directive has done much to implement the Aarhus Convention on Public Participation in Environmental Matters[24] and, in particular, calls for public participation in "the preparation of plans and programmes relating to the environment, within a transparent and fair framework".[25] In R (Greenpeace) v Secretary of State for Trade and Industry, these grounds were used to challenge the government's nuclear policy, which was quashed due to procedural unfairness in the consultation process. Indeed, in the decision of the Court, Sullivan J notes that where projects fall under the remit of the Aarhus Convention, only "the fullest public consultation" would do.[26]

The second route comes under the tort of nuisance. As Scotford has argued,[27] environmental issues bring together human rights, property and nuisance law, and it stands to reason that public engagement should draw on this relationship. Under the Human Rights Act, judges are required to interpret legislation in a manner compatible with the European Convention on Human Rights.[28] Article 1 of the First Protocol to this Convention ensures that "every natural or legal person is entitled to peaceful enjoyment of their possessions", with allowances made only for overriding public interests.[29] These provisions are mirrored closely in nuisance law. Following Rylands v Fletcher, property owners have a right to "quiet enjoyment" of their land,[30] while under Adams v Ursell, exceptional public benefit may override nuisance.[31] Significantly, Watson v Croft Promo-Sport established that Courts are able to look beyond planning permission or other local government directives when assessing nuisance.[32] This approach was applied in Barr v Biffa Waste, where local residents challenged a waste disposal plant and, finding in their favour, the Court of Appeal looked past the fact that the plant had been operating within its Environment Agency licence.[33]

Here, nuisance offers an especially important means of public engagement, as it enables individuals to directly question the impact of decision-making on their property and lives. What is more, there is "no absolute standard" against which nuisance should be measured and it is instead tied to the concept of the ever-evolving 'reasonable user'.[34] This notion applies equally to the standards used in judicial review; the information that should be considered by regulatory administrators inevitably changes with time, as the Massachuetts case makes particularly clear. As such, the Courts can be seen to provide a valuable mechanism for direct public engagement with regulation, ensuring not only that voices are heard, but that they are considered; and where even a considered decision results in unreasonable environmental damage, grounds remain for challenge.

**Conclusion**

A great deal it at stake in environmental regulation. Given the extent of its impact on the public, deliberative democracy might initially seem the only just means of

[19] *CCSU v Minister for the Civil Service* [1984] UKHL 9
[20] Treaty Establishing the European Community, Article 5
[21] *World Wildlife Fund v. Autonome Provinz Bozen* [2000] 1 C.M.L.R. 149
[22] *Berkeley v Secretary of State for the Environment* [2000] 3 AII ER 897
[23] *Massachusetts v. Environmental Protection Agency.* [2007] 549 U.S. 497
[24] Lee, 47
[25] Aarhus Convention, Article 7
[26] *R (Greenpeace) v Secretary of State for Trade and Industry* [2007] EWHC 311
[27] Scotford, 1035
[28] Human Rights Act, s 3
[29] European Convention on Human Rights, Protocol 1, Article 1
[30] *Rylands v Fletcher* [1886] UKHL 1
[31] *Adams v Ursell* [1913] 1 Ch 169
[32] *Watson v Croft Promo-Sport* [2009] 3 All ER 249
[33] *Barr v Biffa Waste Services* [2012] EWCA Civ 312
[34] *Halsey v Esso Petroleum* [1961] 1 WLR 683

shaping environmental policy. However, our discussion has shown that while the model could provide a suitable means of deciding local environmental issues, the sheer scale of environmental regulation means that finding a representative sample to both shape the questions and dictate the solutions seems impractical, if not impossible.

Instead, it is worthwhile considering a shift in perspective; that our focus should perhaps not be on achieving democratisation in decision-making, but on ensuring accountability for the decisions that are made. Here, the mechanisms set out under public law and tort provide practised pathways for members of the public to assert their rights and enact environmental change where decisions fall short. The Courts, too, have demonstrated a long history of adapting the standards for reasonable decision-making in line with the inevitable changes in science and society. While we are unlikely, then, to see the radical restructuring of regulatory decision-making that Extinction Rebellion is pursuing, this is not it itself a failure. Rather, for meaningful public participation in environmental regulation, we need only turn back to the principles on which the field was founded: those cases where individuals were compelled to assert their rights, and were heard.

**Ben Williams**
Student at University of Law, Moorgate

## Lecture to the Royal College of General Practitioners (RCGP) on the Implications of Bawa-Garba and the Boundaries of Professional Conduct, by Kenneth Hamer

Madam chair[35], ladies and gentlemen, it is a great honour as well as a personal pleasure for me to give the 37th George Swift Annual Lecture in memory of Dr George Swift who pioneered GP training in Wessex and was a founder member of the Royal College of General Practitioners. These lectures began in 1981 when George Swift, himself, gave the inaugural lecture on the subject "Recollections and reflections: general practice since 1946". How times have changed in medicine since then!

The title of my talk this evening is *The Implications of Bawa-Garba and the Boundaries of Professional Conduct*. I shall attempt to trace the criminal and professional conduct proceedings in the case of Dr Hadiza Bawa-Garba, that has attracted wide publicity, along with the case of Honey Rose, an optometrist, who like Dr Bawa-Garba faced criminal proceedings of gross negligence manslaughter resulting from treatment to a child who tragically died. These cases are stressful and worrying for all involved and their implications impact seriously on issues of professional conduct and pose the question where do the boundaries lie? In expressing my views in this talk, let me straightaway say that they are my personal views, and should not be taken as necessarily those of any regulator or other body.

I deal, first, with the facts of each case.[36] Dr Bawa-Garba was and is a junior doctor specialising in paediatrics. In February 2011, she had recently returned to practice as a Registrar at Leicester Royal Infirmary Hospital after 14 months of maternity leave. She was employed in the Children's Assessment Unit of the hospital which would receive patients from Accident and Emergency or direct referrals by a GP. Its purpose was to assess, diagnose and, if appropriate, then treat children, or to admit then onto a ward or to the Paediatric Intensive Care Unit as necessary.

Jack Adcock was a six year old boy, who was diagnosed from birth with Downs Syndrome. As a baby, he was treated for a bowel abnormality and a "hole in the heart". He required long-term medication and in the past had been admitted to hospital for pneumonia. On the morning of Friday, 18 February 2011, Jack's mother, Nicola Adcock, took Jack to see his GP. Jack had been very unwell throughout the night and had not been himself the day before at school. The GP was very concerned, and 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. When Jack arrived and was admitted to the assessment unit at the hospital at about 10.15 am, he was unresponsive and limp. Dr Bawa-Garba was the most senior junior doctor on duty. For the following 8 – 9 hours he was in the unit under the care of Dr Bawa-Garba and two other members of staff. At about 7 pm, he was transferred to a ward. During his time at the unit, he was initially treated for acute gastro-enteritis (a stomach bug) and dehydration. After an x-ray he was subsequently treated for a chest infection with

[35] Dr Karen O'Reilly, Faculty Chair, Wessex Faculty RCGP.

[36] The facts are largely taken from the judgments in *Hadiza Bawa-Garba v. The Queen* [2016] EWCA Crim 1841; and *R v. Rose (Honey)* [2017] EWCA Crim 1168, [2018] QB 328.

antibiotics. In fact, when Jack was admitted to hospital, he was suffering from pneumonia 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, at 9.20 pm, Jack died. The cause of death given after a post mortem was systemic sepsis complicating a streptococcal lower respiratory infection (pneumonia) combined with Down's Syndrome and the repaired hole in the heart.

Honey Rose is a registered optometrist. She was first registered with the College of Optometrists on 13 February 2008. In 2012, she worked part time at Boots Opticians in Upper Brook Street, Ipswich as a locum optometrist. On 15 February 2012, Joanne Barker took her two children, Vincent and Amber, to Boots Opticians in Ipswich for routine eye tests and examinations. Vincent was aged 7 years and 9 months and Amber was nearly 5. On that day, Ms Rose was on duty. Vincent was unco-operative when she tried to use an ophthalmoscope to examine the back of his eyes, although she carried out a sight test after retinal images were taken by an optical consultant/assistant. Following Vincent's examination, Ms Rose recorded no issues of concern and said that Vincent did not need glasses. The clinical record card which she filled out recorded the visit as a routine check and that Vincent had had a few headaches over Christmas 2011, but now all gone. Vincent's mother and Amber also had sight tests and eye examinations carried out by Ms Rose. The three appointments lasted 1 hour and 40 minutes.

Five months later, on 13 July 2012 whilst at school, Vincent was taken ill and vomited. The school rang his mother at about 2:50 pm and she collected him and took him home. His condition deteriorated during the afternoon. Around 8 pm he was discovered to be cold to the touch and plainly very ill indeed. The emergency services were called, and paramedics attended. Efforts were made to resuscitate Vincent and he was rushed to Ipswich Hospital. By the time he arrived at hospital, however, Vincent was unfortunately in cardiac arrest. Every effort was made by the ambulance staff, doctors and nurses to resuscitate him, but after 40 minutes there was still no cardiac output. Following consultation with his parents, it was decided that resuscitation would be stopped, and Vincent was formally pronounced dead at 9:27 pm by the on-call paediatrician. Vincent had previously been a healthy, thriving and active boy, who had never before attended hospital.

When a child dies suddenly and unexpectedly, the Sudden Unexpected Death in Infants and Children Protocol, called SUDIC, is implemented. A post-mortem examination of Vincent revealed the cause of death had been acute hydrocephalus (i.e. an acute build-up of cerebrospinal fluid within the normal ventricles of the brain because its normal outlet had been blocked). The condition would have been discovered had Ms Rose examined the back of Vincent's eyes through an ophthalmoscope or "slit" lamp, and would have been treatable by surgical intervention up until the point of his acute deterioration and demise on 13 July 2012.

Dr Bawa-Garba and Ms Rose were each charged with gross negligence manslaughter. In the case of Dr Bawa-Garba the Crown's case was that she, together with the nurse on duty and ward sister, contributed to, or caused Jack's death, by serious neglect which fell so far below the standard of care expected by competent professionals that it amounted to criminal conduct. Following trial at Nottingham Crown Court Dr Bawa-Garba and Nurse Amaro, the nurse on duty, were both convicted by a jury and each was sentenced to 2 years' imprisonment suspended for 2 years. The ward sister was acquitted. In December 2016, Dr Bawa-Garba's appeal was dismissed by the Court of Appeal, Criminal Division, but the Medical Practitioners Tribunal Service decided not to erase her name from the medical register and instead to suspend her registration for one year. Her registration is now subject to conditions although she has yet to resume clinical practice. Nurse Amaro was struck off by the Nursing and Midwifery Council.

Ms Rose too was convicted by a jury and sentenced to 2 years' imprisonment suspended for 2 years, but her appeal was allowed by the Court of Appeal, Criminal Division on the ground that the trial judge misdirected the jury on a point of law. The Court of Appeal held that to be guilty of gross negligence manslaughter Ms Rose would have had to have reasonably foreseen a serious and obvious risk of death at the time of her examination of Vincent, which was not made out on the facts.[37]

[37] The offence of gross negligence manslaughter requires breach of an existing duty of care which it is reasonably foreseeable gives rise to a serious and obvious risk of death and does, in fact, cause death in circumstances where, having regard to the risk of death, the conduct of the defendant was so bad in all the circumstances as to go beyond the requirement of compensation but to amount to a criminal act or omission; per Sir Brian Leveson P handing down the judgment of the court in *R v. Rose (Honey)* [2018] QB 328 at para 77; see further *R v. Rudling* [2016] EWCA Crim 741 at para 18, and *R v. Sellu* [2017] 4 WLR 64.

However, Ms Rose remains suspended from practising her profession.

These cases show us a number of things. First, that a healthcare professional may face both criminal and professional conduct proceedings arising from the same incident or set of facts. The modern era of regulation of the medical profession began with the Medical Act 1858. The 1858 Act brought together the disciplinary processes of the Royal College of Physicians that was first chartered in 1518, the College of Surgeons established in 1745, the Society of Apothecaries and other medical bodies. It provided for the establishment of the General Council of Medical Education and Registration of the United Kingdom, later to be called the General Medical Council. Section 29 stated that if any registered medical practitioner shall be convicted in England or Ireland of any felony or misdemeanour, or in Scotland of any crime or offence, or shall after due inquiry be judged by the General Council to have been guilty of infamous conduct in any professional respect, the General Council may, if they see fit, direct the Registrar to erase the name of such medical practitioner from the register. These provisions are reflected today in the fitness to practise processes in the Medical Act 1983 and the Opticians Act 1989, which govern the medical and optical professions.

Secondly, the regulator will usually allow the criminal proceedings to proceed first to a conclusion. However, an acquittal in the criminal proceedings is no bar to subsequent professional conduct proceedings. Double jeopardy plays no part in this area of the law.[38] The whole process may last some years before being completed. During this time the practitioner's career may be on hold, often subject to an interim suspension order or an interim conditions of practice order. Moreover, the practitioner may become de-skilled as a result of lengthy court and regulatory investigations and proceedings.

Thirdly, it is important to bear in mind that there is a fundamental difference between the task and necessary approach of a jury on the one hand and that of a tribunal in professional conduct proceedings on the other hand. The task of the jury is to decide the guilt or absence of guilt of the defendant having regard to his or her past conduct. The task of the tribunal, looking to the future, is to decide what sanction would be most appropriate to meet the objectives of the regulator.[39] Section 1 (1A) of the Medical Act 1983 provides that the over-arching objective of the General Medical Council in exercising their functions is the protection of the public. This involves the objectives 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 standards and conduct for members of the profession.[40] Similar provisions appear in the Opticians Act 1989, and in the legislation of all the healthcare professions.

On 11 June 2018 the Secretary of State for Health and Social Care announced that the Government would support the recommendations of the Williams Review into gross negligence manslaughter in healthcare. Professor Sir Norman Williams' report *Gross Negligence Manslaughter in Healthcare*[41] was set up to consider the wider patient safety impact resulting from concerns among healthcare professionals that simple errors could result in prosecution for gross negligence manslaughter, even if they occur in the context of broader organisation and system failings. Despite reports to the contrary, investigations of gross negligence manslaughter in healthcare are unusual, prosecutions are rare and findings of guilty are rarer still.[42] There is no doubt, however, that recent cases have led to an increased sense of fear and trepidation, creating great unease within healthcare professions. The Williams report was clear that healthcare professionals could not be, or seen to be, above the law and needed to be held to account where necessary. It was equally evident, however, that for the sake of fairness, the complexity of modern healthcare and stressful environments in which professionals work must be taken into consideration when deciding whether to pursue a gross negligence manslaughter investigation. The Williams report made a series of recommendations[43] designed to see that

[38] *R (Redgrave) v. Commissioner of Police of the Metropolis* [2003] EWCA Civ 4, [2003] 1 WLR 1136 CA.

[39] *General Medical Council v. Bawa-Garba (British Medical Association and others intervening)* [2018] EWCA Civ 1879, [2019] 1 WLR 1929 CA at [76].

[40] Section 1 (1B) of the Medical Act 1983

[41] https://www.gov.uk/government/publications/williams-review-into-gross-negligence-manslaughter-in-healthcare

[42] In the period January 2013 to March 2018, a total of 151 cases were investigated by the police and CPS resulting in no further action in 128 cases, 4 convictions and 3 acquittals and 16 ongoing cases.

[43] Recommendations include a clear explanatory statement of the law of gross negligence manslaughter and updated guidance and understanding of where the threshold for prosecution lies, improving assurance and consistency in the use of experts in gross negligence manslaughter cases, consolidating expertise in

systemic issues and human factors will be considered alongside the individual actions of healthcare professionals where errors are made that lead to a death, ensuring that the context of an incident is explored, understood and taken into account. Additionally, bereaved families need support through being informed, in a timely manner, of events; being provided with the opportunity to be involved throughout investigative and regulatory processes; and at all times treated with respect and receive honest explanations when things have gone wrong.

In addition to the Williams Review, the General Medical Council commissioned its own review of gross negligence manslaughter and culpable homicide, which reported in June 2019.[44] Its focus was on how the systems, procedures and processes surrounding the criminal law and medical regulation are applied in practice and how they can be improved to support a more just and fair culture. The review recognized that many doctors feel unfairly vulnerable to criminal and regulatory proceedings should they make a mistake which leads to a patient being harmed. The review made 29 recommendations. These included steps to rebuild the GMC's relationship with the profession; that the GMC should work with others across the healthcare systems to ensure that the importance of an inclusive culture is understood within the workplace; and that where a doctor is being investigated for gross negligence manslaughter or culpable homicide, the appropriate external authority should scrutinise the systems within the department where the doctor worked. Where the doctor is a trainee, this should include scrutiny of the education and training by bodies responsible for education and training. In short there needs to be better system scrutiny and assurance.

In the *Bawa-Garba* criminal proceedings, the trial judge in his sentencing remarks took into account the circumstances in which the offences took place, and that the children's unit at the hospital was a busy ward and could not limit its intake, but said there was a limit to how far these issues could be explored in a criminal trial, although there may be force in the argument that the defendants' responsibility was shared with others. This aspect was explored further in the subsequent fitness to practise proceedings against Dr Bawa-Garba and figured extensively in the determinations on impairment and sanction of the Medical Practitioners Tribunal. The tribunal found that Dr Bawa-Garba's actions marked a serious departure from *Good Medical Practice* and contributed to Jack's early death which continued to cause great distress to his family. Multiple systemic failures were identified by the Trust in its investigation following the incident. The Trust investigation included failings on the part of the nurses and consultants, medical and nursing staff shortages, IT system failings which led to abnormal laboratory test results not being highlighted, deficiencies in handover and accessibility of the data at the bedside, and the absence of a mechanism for an automatic consultant review. The tribunal found that Dr Bawa-Garba's fitness to practise was and remains impaired by reason of her conviction, but it was satisfied that the risk of her putting a patient at unwarranted risk of harm in the future was low. There was no evidence of any concerns being raised regarding Dr Bawa-Garba's clinical competency before or after the offence and there was no evidence to suggest that her actions on 18 February 2011 were deliberate or reckless. She was described by colleagues as an excellent doctor who had also reflected deeply on the events and demonstrated significant and substantial insight. The tribunal concluded that the goal of maintaining public confidence in the profession would be satisfied by suspension of Dr Bawa- Garba's registration.

As is well known, and was widely reported in the press, the General Medical Council appealed the sanction decision and the Divisional Court quashed the tribunal's direction of 12 months' suspension and substituted a direction of erasure from the medical register.[45] Dr Bawa-Garba was granted permission to appeal and her appeal was eventually successful in the Court of Appeal.[46] In giving the judgment of the appeal court Lord Burnett of Maldon CJ, Sir Terence Etherton MR and Rafferty LJ said that the tribunal had been entitled to take into account that an important factor weighing in the doctor's favour was that she was a competent and useful doctor who presented no material danger to the public, and can provide considerable useful future service to society; and that the tribunal in carrying out an evaluative judgment was best qualified to judge what measures were required to maintain the standards and reputation of the profession.[47]

healthcare settings in support of investigations, and improving the quality of local investigations.

[44] *Independent review of gross negligence manslaughter and culpable homicide,* June 2019, published by GMC.

[45] [2018] EWHC 76 (Admin); [2018] 4 WLR 44, DC

[46] [2018] EWCA Civ 1879; [2019] 1 WLR 1929, CA

[47] See paras 93-97 applying *Bijl v. General Medical Council* [2002] Lloyd's Rep Med 60 at [13]; *Marinovich v. General Medical Council* [2002] UKSC 36 at [28]; and *Khan v. General Pharmaceutical Council* [2017] 1 WLR 169, SC at [36].

Consequently, the suspension imposed by the tribunal was restored and the matter remitted to the MPTS for review.

On 9 April 2019 a tribunal determined that Dr Bawa-Garba's fitness to practise remained impaired by reason of her conviction but that her suspension from the register should be replaced by a conditions of practice order for 24 months. In the case of Honey Rose, she remains suspended under an interim order pending determination of her case before the Fitness to Practice Committee of the General Optical Council.[48]

What then are the implications of these and similar cases and where are the boundaries of professional conduct in cases involving gross negligence manslaughter? In considering the effect or consequences of the Bawa-Garba and Honey Rose cases, it seems to me that the striking feature is how society can fairly and justly balance the disparate interests of the patient and the doctor and the state and the regulator. I have already referred to the interests of and the support required to the bereaved families. These must be balanced against the rights of the doctor whose interests require to be protected by a fair investigation and trial process. Anonymity of the practitioner in any criminal or regulatory proceedings is unlikely save where the health or the need to protect the privacy or confidentiality of the practitioner outweighs the public interest. We live in a society of open justice and the press plays an important role and, subject to well established exceptions, hearings are conducted in public. This may be hard on the individual healthcare worker, who may have an otherwise unblemished career and the incident may be an isolated act or series of events in the course of treatment or care to a single patient, but this must be balanced against the overarching objectives to promote and maintain public confidence in the profession concerned and maintain proper standards of conduct for members to abide by.

It remains to be seen how the recommendations of the Williams Review and the GMC's own review will change the cultural environment and provide better reassurance to healthcare professionals, patients and families in cases of gross negligence manslaughter. Both reviews recognized the concerns expressed by many healthcare professionals about the possible use of reflective records and other reflective material, such as e-portfolio reflective statements, in prosecuting a healthcare professional for gross negligence manslaughter. The GMC has stated that reflection is central to learning and to safe practice and fundamental to medical professionalism. Reflection supports doctors' learning and may lead to better personal insight and improved practice and better patient safety. At no point during the criminal trial was Dr Bawa-Garba's e-portfolio reflective statement presented to the court or jury as evidence. The doctor shared some personal reflection with the tribunal in the fitness to practise proceedings to demonstrate the steps she had taken to remediate her practice.

The Human Rights Act 1998 plays an important part in criminal and regulatory proceedings. The Act incorporates into English law the European Convention on Human Rights. Article 6 of the Convention provides for a right to a fair trial in criminal and civil proceedings and confirms the common law rule that everyone charged with a criminal offence shall be presumed innocent until proved guilty according to law. In criminal and civil proceedings the burden of proof remains throughout on the prosecution or the regulator whatever the nature of the proceedings. Article 2 of the Convention provides that everyone's right to life shall be protected by law. Following a sudden and unexpected death there may be an inquest,[49] and a police investigation which may lead to a decision by an independent prosecuting authority whether to bring criminal proceedings against the practitioner. It has been held that there is nothing in the Strasbourg or domestic jurisprudence that requires disciplinary proceedings to be taken in order to meet the requirements of article 2,[50] although it would be for the court, if necessary, to determine whether there has been sufficient scrutiny such that it is not necessary to pursue disciplinary proceedings.

In Bawa-Garba and Honey Rose there was plainly serious negligence in each case. In allowing the appeal in the criminal proceedings in the *Honey Rose* case, the Court of Appeal said it did not, in any sense, condone the negligence that the jury must have found to have been established at a high level in relation to the way Ms Rose examined Vincent and failed to identify the defect which ultimately led to his death. That serious

[48] Review of Interim Order dated 16 August 2019.

[49] See *R (Middleton) v. West Somerset Coroner and another* [2004] UKHL 10, [2004] 2 AC 182 where at [20] Lord Bingham of Cornhill said that in England and Wales an inquest is the means by which the state ordinarily discharges its obligation under article 2.

[50] *R (Birks) v. (1) Commissioner of Police of the Metropolis and (2) Independent Complaints Commission and Rigg-Samuel (Interested Party)* [2018] EWHC 807 (Admin) at [46] *et seq*

breach of duty, the court said, was a matter for her regulator, the General Optical Council.[51] Similarly, in the *Bawa-Garba* case, the jury found that the conduct was truly exceptionally bad and the tribunal found that Dr Bawa-Garba fell far below the standards expected of a competent doctor at her level. Her failings in relation to Jack were numerous, continued over a period of hours and included a failure to reassess Jack following her initial diagnosis or seek assistance from senior consultants. The real argument was over sanction and whether, as contended by the GMC, Dr Bawa-Garba's name should be erased from the register.

Any sanction imposed by a fitness to practise tribunal is not intended to be punitive but to protect patients and the public. Most tribunals will wish to explore the extent to which the practitioner has practised safely since the incident, has fully remediated any concerns about their clinical practice and has demonstrated real insight into the failings that brought the practitioner before the tribunal. A matter of importance is whether the conduct of the practitioner or deficiencies in professional performance are so egregious that nothing short of erasure or removal from the register is required. Undoubtedly, there are some cases where the facts are such that the most severe sanction, erasure, is the only proper and reasonable sanction.[52] The assessment of the seriousness of the misconduct, particularly when it relates to professional performance, is essentially a matter for the tribunal in the light of their experience. Much will depend on the evidence placed before the tribunal, the personal circumstances of the practitioner, what support the practitioner may have, and how great is the risk of putting a patient at unwarranted harm in the future.

At the MPTS most hearings are now chaired by a legally qualified lawyer and the tribunal will include at least one medical practitioner on it. The tribunal will be guided by any published sanctions guidance or policy issued by the regulator, but any sanctions guidance, which is said to be "indicative", is a starting point and the sanction imposed in each case must be fact sensitive and, crucially important, be judged as being fair and proportionate to the interests of the registrant when weighed against the backdrop of the public interest and the maintenance of public confidence in the profession. Any sanction or penalty, like any sentence, is ultimately a matter of judgment for the tribunal or sentencer, rather than proof and in deciding what sanction, if any, to impose the tribunal will consider each of the options available under the legislation, starting with the least restrictive.

Bringing these strands together, the cases of Dr Bawa-Garba and Honey Rose each show that the process whilst lengthy is thorough and considerable care is taken in the interests of justice at each of the various stages of the process. The purpose of this lecture, however, is not to discuss case management but the implications of these and similar cases for the parties involved and the wider public. In her Fifth Shipman Report, Dame Janet Smith reminded us of the notorious case of Alfie Winn.[53] In 1982, Alfie Winn, a child aged eight years, became ill with vomiting and a high temperature. His general practitioner was called and attended upon Alfie, who was asked to open his mouth. The boy seemed comatose and the doctor said that if Alfie could not be bothered to open his mouth, he would not examine him. He prescribed an antibiotic. Two hours later, the family called an ambulance and Alfie was taken to hospital. He died four days later of meningitis. The professional conduct committee of the GMC found the facts proved and held that the doctor's behaviour did fall below acceptable standards. Nonetheless, it considered it did not cross the threshold for a finding of serious professional misconduct. The case attracted wide publicity with questions in Parliament and the GMC's then guidance *Professional Conduct and Discipline: Fitness to Practise*, known as the Blue Book, was amended to emphasise that the public are entitled to expect that a registered medical practitioner will afford and maintain a good standard of medical care.

The need to promote and maintain a good standard of medical care is reflected today in the words of section 1 (1A) of the Medical Act which, as I have mentioned, provides that the over-arching objective of the GMC in exercising their functions is the protection of the public, along with the objectives in section 1 (1B) of the Act which include to protect, promote and maintain the health, safety and well-being of the public.

Madam chair, the protection of the public and the health, safety and well-being of the public must surely be the aims of all concerned who are engaged in these distressing and often difficult cases, whether as doctor or other healthcare professional, regulator, employer,

[51] *R v. Rose (Honey)* [2018] QB 328 at para 95

[52] *GMC v. Bawa-Garba* [2018] EWCA Civ 1879, per Lord Burnett of Maldon CJ at [87]

[53] Fifth report of the Shipman Inquiry, 9 December 2004 (Cm 6394), paras 17.11 – 17.12

lawyer or associate. In discharging our respective functions, I am confident we will all keep well in mind the motto that the founders of this Royal College decreed, which is *Cum Scientia Caritas* – "Compassion [empowered] with Knowledge". Thank you.

**Kenneth Hamer**
Henderson Chambers


## Review of The Regulation of Healthcare Professionals: Law, Principle and Process, 2nd Edition by David Gomez and contributors, reviewed by Nicole Curtis of Bates Wells

The new edition of "The Regulation of Healthcare Professionals", published by Sweet and Maxwell earlier this year, contains detailed guidance on regulatory and disciplinary law and practice in the field of healthcare.

David Gomez and contributors have produced a comprehensive work, covering the entire regulatory cycle from students' fitness to practise and initial registration, through to the process of maintaining registration by CPD and revalidation, and covering all aspects of the fitness to practise process, including impairment, sanctions, appeals and restoration to the register. It covers the nine statutory healthcare regulators (with detailed chapters on each), the Care Quality Commission in England and the Royal College of Veterinary Surgeons. There is also a chapter covering the Professional Standards Authority, including its key thinking on regulatory policies and approaches, and the case law deriving from 's.29 appeals'. In relation to the wider NHS in England, the book covers complaints and investigations of patient safety incidents in the NHS, the Performers and Pharmaceutical list and the conduct, capability and health procedures contained in "*Maintaining High Professional Standards in the Modern NHS*".

The work is described as sitting "*firmly at the confluence of law and policy*", with detailed legislative tables linking principles derived from case law to the relevant provisions for each regulator.

The new edition brings with it a number of new chapters, including a chapter dealing with the regulation of healthcare professionals in Scotland and an entire chapter on dishonesty, including the professional duty of candour. There is also a new chapter on whistleblowing, and one covering aspects of criminal liability.

This second edition comes amongst change and reorganisation within the NHS and the regulatory landscape for healthcare professionals. The text notes that a whole model of accredited registers is now operational in respect of non-statutory healthcare professions and that revalidation is now well established amongst a number of regulators, including the General Medical Council. It also notes the launch of Social Work England which will take on regulatory responsibility from the Health and Care Professions Council at the end of this year.

Joanna Glynn QC is a consultant and editor emeritus to the second edition, and the text contains contributions from Paul Ozin QC, Peter Mant, Ros Foster, Christine O'Neill, Duncan Mawby and Niall McLean, together with research assistance from Kabir Siddiqui.

This is a comprehensive and very helpful text for all practitioners in the regulatory field, and would be of assistance to legal representatives, legal assessors and members of fitness to practise or conduct and competence panels. The book would also be of interest to policy makers operating in the fields of healthcare regulation and fitness to practise.

**Nicole Curtis**
Bates Wells

## Legal Update

***Sanusi v. General Medical Council* [2019] EWCA Civ 1172**

*Adjournment prior to sanction – no general obligation of tribunal to adjourn prior to sanction – registrants to be warned of potential consequences of failure to attend hearing*

The appellant appealed against the decision of the tribunal not to adjourn after the findings of misconduct to give him an opportunity to make submission on sanction. Kerr J dismissed the appellant's appeal, and his decision was upheld by the Court of Appeal. Giving

the judgment of the Court of Appeal, Simler LJ (with whom Richards LJ and Theis J agreed) said that in *GMC v. Adeogba* [2016] EWCA Civ 162, Sir Brian Leveson P made clear that the tribunal must be satisfied that all reasonable efforts have been taken to notify the practitioner of the hearing consistent with the rules, but once so satisfied, discretion whether or not to proceed must then be exercised having regard to all the circumstances of which the tribunal is aware with fairness to the practitioner being a prime consideration but fairness to the GMC and the interests of the public also taken into account. Sir Brian Leveson went on to say that to suggest that a practitioner must be allowed one (or perhaps more than one) adjournment is to fly in the face of the efficient despatch of the regulatory regime. An adjournment is highly disruptive to members of the panel, the legal assessor, staff and to organise another hearing is both disruptive and inconvenient. A culture of adjournment is to be deprecated. Although attendance by the practitioner is of prime importance, it cannot be determinative. Simler LJ, at [68 – 78], said that those considerations apply with equal, if not greater, force to adjournments part way through a hearing, including, if it is reached, immediately before consideration of sanctions. There is no general obligation on a tribunal to adjourn or provide a registrant with the opportunity to make submissions in mitigation of sanction once adverse findings have been made against him or her. The approach adopted in *Sukul v. BSB* [2014] EWHC 3532 (Admin) and *Lawrance v. GMC* [2015] EWHC 586 (Admin) inadequately recognises the nature and objective of the regulatory system in play and the significant disruption caused by the culture of adjournment sanctioned by it. In a case where the registrant chooses not to attend a tribunal hearing (for good or bad reason) he or she must be taken to appreciate that if adverse findings are made, they will not be in a position to address the tribunal on matters of mitigation in any changed circumstances flowing from those adverse findings and will be entirely reliant on any written submissions or representations made by the registrant in advance of the hearing; see *Elliott v. Solicitors Disciplinary Tribunal and another* [2004] EWHC 1176 (Admin). The position is likely to be different where there is unchallenged medical evidence that a registrant, who was otherwise fully engaged in the disciplinary process, is taken ill and so is not fit to attend the hearing or part of it; or where there is come other compelling reason justifying an adjournment. The court commended two amendments made by the GMC to the standard letters sent to registrants facing fitness to practise hearings. First, a specific warning is given that if a registrant does not attend the hearing, the tribunal could impose a sanction without seeking further representation. Secondly, registrants are now provided in advance of the hearing with a written indication of the GMC's proposed submissions on the appropriate sanction and directed to the Sanctions Guidance.

***Antino v. Royal Institution of Chartered Surveyors,* Appeal Panel, 10 May 2019**

*Judicial immunity - Party wall surveyor – differences between party wall proceedings and judicial proceedings - whether judicial immunity on public policy grounds – no justification for extending immunity to party wall surveyor for misconduct during making of an award*

PA appealed against a decision of an RICS disciplinary panel who found that he was liable to disciplinary action whilst acting as a party wall surveyor. PA contended that the disciplinary panel had erred in law in finding that party wall surveyors do not have judicial immunity. Dismissing PA's appeal the Appeal Panel (Sir Michael Burton, chairman) said that arbitrators have long had judicial immunity at common law, though since the introduction of the Arbitration Act 1996, by section 29, they no longer have immunity where they act *mala fide.* No similar duty is applicable to party wall surveyors. The appeal panel considered the differences and similarities between the procedure under the Party Wall Act 1966 and judicial or arbitration proceedings. The differences far exceeded the number of similarities. The differences included:

- No procedure in the Party Wall Act for hearing evidence or submissions;
- No procedure in the Act for disclosure;
- It is not clear what evidence the party wall surveyor will rely on – i.e. he is not limited to the information the parties put before him;
- There is no requirement for a hearing in public or otherwise;
- No witnesses called on oath or otherwise;
- No ability to compel evidence;
- No judicial training or assistance;
- No formal qualifications needed at all;
- The party wall surveyor investigates, rather than adjudicates, which is a non-judicial function;

- Unlike a judge or arbitrator, he can rely on an opinion which has not been ventilated before the parties to reach his decision.

The appeal panel said that no authority was presented to it in which judicial immunity has ever been applied, at common law or otherwise, to party wall surveyors, or to surveyors acting in an equivalent role. Public policy protects judges and arbitrators, and there can be no justification for extending immunity to any dispute-resolver. In the case of a party wall surveyor's decision, there can be no challenge to his award under section 10 (16) of the Act in the interest of finality, but there must be a positive public policy in favour of his conduct being able to be monitored by his professional body: for example in relation to misconduct prior to or in the course of the award, as exemplified by some of the facts considered in the instant case.

***Rak-Latos v. General Dental Council*** **[2018] EWHC 3503 (Admin)**

*Conviction of aiding and abetting fraud in Poland—supplying blank medical prescriptions for gain—misleading, but not dishonest, failure to inform GDC of conviction—misconduct—evidence inconsistent with conviction inadmissible despite conviction outside UK—sanction of erasure warranted*

The practitioner was a dentist who was registered to practise in Poland and the United Kingdom. In September 2015, she was convicted by the Kielce Regional Court in Poland of aiding and abetting fraud. Between 2007 and 2013, R-L provided forty-four blank prescriptions to her sister, a pharmacist, which were used to defraud the Polish National Heath Fund out of 22,800 zloty (approximately £4,700). On 6 October 2015, the practitioner was sentenced by the Polish Court to a term of one year's imprisonment, suspended for two years. She did not report the conviction to the GDC when moving to England in December 2016 to work as a dentist in a London clinic. When the GDC learned of the conviction, it commenced disciplinary proceedings. On 25 May 2018, the PCC found that the practitioner's fitness to practise was impaired by reason of her conviction for aiding and abetting fraud, that she had failed to inform the GDC of the conviction, and that her failure to do so was misleading, although not dishonest. The PCC directed that her name should be erased from the register. The practitioner appealed on three grounds: (1) that the PCC was wrong to find misconduct in her failure to report her conviction; (2) that the PCC was wrong to find that her fitness to practise was impaired; and (3) that the sanction of erasure was disproportionate. The Court (Pepperall J) dismissed all three grounds. As to ground 1 (failure to report), the Court said that the case involved a conviction of aiding and abetting prescription fraud. This was not a minor misdemeanour whereby a professional person might reasonably conclude that there was no duty to report the conviction. The Committee accepted that she had acted in a misleading, rather than deliberately dishonest, way. In so finding, the Committee properly took into account the practitioner's ill-health and the possibility of confusion as to the need to report the conviction to the English regulator. As to ground 2 (impairment of fitness to practise), the PCC was provided with an English translation of the judgment of the Polish Court. The practitioner protested her innocence of fraud and claimed that she did not know that her sister was taking blank prescriptions from the dental practice in Poland. She pointed towards the fact that her conviction was pursuant to article 18.3 of the Polish Criminal Code, which deals with secondary liability. She said that her sister was clinically depressed and feared that if she were to incriminate her sister in stealing the blank prescriptions from the dental practice, her sister might be imprisoned. Pepperall J said that whilst rule 57 of the General Dental Council (Fitness to Practise) Rules 2006, which provides that a copy of a certificate of conviction in the United Kingdom shall be conclusive proof of the conviction, was not engaged since the conviction had not been made in the United Kingdom, nevertheless the PCC was right to take the conviction at face value and to reject evidence whereby the practitioner sought to present an account of events that was inconsistent with her conviction (see *Shepherd v. Law Society* [1996] EWCA Civ 977, *Hunter v. Chief Constable of West Midlands Police* [1982] AC 529, *Kirk v. The Royal College of Veterinary Surgeons* [2004] UKPC 4, and *General Medical Council v. Spackman* [1943] AC 627). As to ground 3, the decision to direct erasure was an evaluative judgment by a specialist committee and erasure was warranted.

***Schulze Allen v. Royal College of Veterinary Surgeons*** **[2019] UKPC 34**

*Conviction for petty theft in California – infraction – whether conviction a criminal offence – section 16(1)(a) Veterinary Surgeons Act 1966*

On 25 September 2013, in the Superior Court of California, County of San Bernardino, Dr Schulze Allen

(SA) pleaded guilty under a plea bargain and was convicted of "petty theft under $50 without prior". His offence was stealing a package of superglue worth $1.48. He was ordered to pay a fine of $435, plus fees. By an application dated 3 December 2013, SA applied to the Royal College for restoration of his name to the register of veterinary surgeons, his name having previously been removed in 2010 for non-payment of his annual renewal fee when he went to work in California. In answer to questions on the application form and in supporting documents, SA stated that he had no previous convictions in the UK or elsewhere and knew of no "adverse findings" against him in the UK or overseas. SA did not declare the offence in California and on 10 December 2013 SA was restored to the register. Following a complaint made to the Royal College in early 2016 about SA's work as a locum veterinary surgeon in Horsham, West Sussex, the record of SA's conviction in California was discovered. The Royal College brought four charges against SA. The first charge was being convicted of a *criminal* offence in the UK or elsewhere contrary to section 16(1)(a) of the Veterinary Surgeons Act 1966. The second to fourth charges were of disgraceful conduct under section 16 (1) (b) of the Act in relation to answers given by SA when applying for restoration to the register. The Disciplinary Committee found all four charges proved and on 9 January 2018 directed that SA's name should be removed from the register. The evidence before the committee included the court record in California which showed that SA had indeed been the subject of a conviction, but its severity was shown as an "infraction". SA appealed against the decision and sanction to the Privy Council (Lord Wilson, Lord Carnwath and Lord Lloyd-Jones) on the grounds that an infraction is not a *criminal* offence in California and is treated as a minor transgression. SA adduced further evidence with the Royal College's agreement and which the Privy Council said it would have permitted. The evidence included a decision of the Administrative Law judge in California who had heard SA's appeal against the refusal by the Medical Veterinary Board on his application for a licence. The administrative law judge stated that there was Californian appellate authority for the proposition that infractions are not 'crimes' and concluded that SA had "at least a colourable argument that he has never been convicted of a criminal offence". The Privy Council therefore held that on the evidence the Royal College had not discharged the burden of proving beyond reasonable doubt that SA was convicted of a *criminal* offence under Californian law. The appeal was allowed as to the first charge and the charges of dishonestly stating on his application for registration that he did not have a "criminal" conviction in the United Kingdom or elsewhere. But it dismissed the appeal against the committee's decision that SA had been guilty of disgraceful conduct in answering "no" to the question "Do you have any …. adverse findings, including professional disciplinary proceedings against you, whether in the UK or overseas?" The Board remitted to the committee the appropriate sanction on this charge.

***Opare v. Nursing and Midwifery Council* [2019] EWHC 1851 (Admin)**

*Fleischmann principle – need for panel to consider appropriate sanction before considering Fleishmann principle*

In July 2018 the appellant was convicted in the magistrates' court of dishonestly making a false representation and received a suspended custodial sentence. She was subsequently struck off the register by the NMC, the panel noting that she was subject to the suspended sentence until March 2020 and that the maximum period of suspension the panel could impose was 12 months which would not have expired by March 2020. In dismissing the appellant's appeal against the decision to strike her off the register, Lane J said that it was important to make the observation that the panel had reached the conclusion that the appropriate sanction was striking off and not one that involved suspension before (emphasis in judgment) it turned to considered what effect the case of *Fleischmann* had: see *Council for the Regulation of Health Care professionals v. General Dental Council and Fleischmann* [2005] EWHC 87 (Admin), per Newman J at [54]. The panel did not err in its consideration of the *Fleischmann* principle. It noted that it was "a general principle" that a practitioner should not be permitted to resume practice until he had satisfactorily completed his sentence. It was appropriate for the panel to refer to the suspended sentence as still being in force at the time it took its decision and that it would continue until March 2020. There was no reason to read the panel's decision in the present case as a decision that turned upon the application of the *Fleischmann* principle; but even if that were otherwise, the panel had already correctly, and without error, reached the conclusion that suspension was not appropriate.

**Kenneth Hamer**
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## Request for Comments and Contributions

We would welcome any comments on the Quarterly Bulletin and would also appreciate any contributions for inclusion in future editions. Please contact either of the joint editors with your suggestions. The joint editors are:

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