ARDL

ASSOCIATION OF REGULATORY & DISCIPLINARY LAWYERS

QUARTERLY BULLETIN – SUMMER 2020

CONTENTS

Page 1: Chairman's Introduction, Paul Ozin QC, 23 Essex Street

Page 3 Covid-19 and the Question of Legal Immunity by Richard Price OBE, QC and Rosalee Dorfman Mohajer

Page 5 The Chief Coroner's Guidance on Covid-19 Deaths in the Workplace by Alexandra Tampakopoulos

Page 6 The Standard of Proof of Dishonesty – Inherent Improbabilities and Evidence of Good Character: McLennan v. General Medical Council by Christopher Geering

Page 8: The Role of the General Medical Council and the Boundaries of Professional Conduct, Talk to South London and Maudsley NHS Foundation Trust by Kenneth Hamer

Page 12: Legal Update, Kenneth Hamer of Henderson Chambers

Page 16: Thanks to Lauren Leigh of Kingsley Napley LLP

Chairman's Introduction

Welcome to the Summer Edition of the ARDL Quarterly Bulletin, which we trust serves as a reassuring example of 'business as usual' in these challenging times. It includes the usual mixture of insightful articles on various aspects of professional regulation and discipline and Kenneth Hamer's invaluable Legal Update. There is inevitably a focus in this edition on matters pertaining to the current health crisis, with two articles specifically addressing issues relating to Covid-19: "Covid-19 and the Question of Legal Immunity" by Richard Price OBE, QC and Rosalee Dorfman Mohajer; and "The Chief Coroner's Guidance on Covid-19 Deaths in the Workplace" by Alexandra Tampakopoulos. The remainder of the articles address developments in the law relating to important perennial issues: "The Standard of Proof of Dishonesty – Inherent Improbabilities and Evidence of Good Character: McLennan v. General Medical Council" by Christopher Geering; and "The Role of the General Medical Council and the Boundaries of Professional Conduct, Talk to South London and Maudsley NHS Foundation Trust" by Kenneth Hamer. In addition to thanking the authors of those articles, I should like to pay tribute to the long-standing editors of the Quarterly Bulletin, Nicole Curtis and Kenneth Hamer, for developing and maintaining a world class publication.

Committee and Administration

At the AGM in April, Iain Miller stepped down as Chair. I was elected as the new Chair and Rachel Birks as the new Vice-Chair. Fiona Muirs and Sam Thomas join the Committee as new members. John Lucarotti, Sara Mason and Vikram Sachdeva QC stepped down from the Committee. Joanne Harrison was elected as the new

Secretary. The Committee wishes to express its gratitude to Iain for his tremendous work as ARDL's Chair and to John, Sara and Vikram for their enormous contributions to the work of the Committee. The newly refreshed Committee aims to build on the firm foundations of its predecessors.

The editors express below their thanks to Lauren Leigh of Kingsley Napley for her work in relation to the production of the Quarterly Bulletin. In addition, I should like to express the Committee's thanks more generally to Lauren and Rachel Graham of Kingsley Napley, for their sterling work as the administrators of ARDL over many years (including in relation to the organisation of the annual dinner); and to welcome Kirsty Bryant of Blake Morgan who takes over those functions.

Seminars

Our transition to remote Zoom webinars proceeded first with a webinar on "The new Police Regulations and other recent developments in police regulation" on 19 April and was followed by a webinar on "Global Financial Services Regulation: views from the Cayman Islands, Guernsey and Mauritius" on 4 May. In the coming weeks, additional seminars will be advertised on the following topics: the legal ramifications of remote hearings; legal services regulation; the regulation of BAME professionals and/or the experience of BAME professionals in the regulation of professions. In addition, the Seminar Sub-Committee is energetically engaged in developing a full programme of webinars for the coming months (capable of being converted into real-world seminars if circumstances permit). In the meantime, we enjoy the collateral advantage of the decoupling of the programme from geographical limitations, with the London, Manchester and Scotland seminars open to all members. No doubt, come what may, the remote extension of our seminars will remain in some form as a permanent adjunct to our work.

Mentoring Scheme

The new ARDL Mentoring Scheme, which aims to assist the development of less experienced members of our Association and to enable them to develop successful careers within regulatory and disciplinary law, is now up and running. This is an important and timely endeavour by the Association, which hands to each experienced regulatory practitioner the opportunity personally to make a real contribution to levelling the professional playing field. The informal feedback so far is that both mentors and mentees have found the experience of participating in the scheme very positive. Details of the scheme can be found on the News section of the website. We remain short of mentors. I would encourage members who feel that they could act as a mentor to contact the ARDL administrators.

Equality and Diversity

The Association is committed to promoting equality and diversity in the regulatory sector and to examining its own processes to ensure that they are compliant with best practice in those respects. To that end, our Committee member, Andrew Katzen, has kindly agreed to take the lead in reviewing our processes.

Essay Prize

The judging of the Marion Simmons QC essay prize is underway. I am pleased to report that the number of entries this year has increased significantly. We expect to be able to announce the winner shortly and to publish the winning essay in the Autumn bulletin.

New Website

I believe that this will be the last Chair's Introduction to speak of the imminent arrival of the long-awaited new website. It will, when it arrives, have greater functionality than the present platform; and we think that it will have been worth the wait.

Inaugural One Day Conference

The full programme and line-up of speakers for ARDL's Inaugural One Day Conference has now been confirmed. It will be advertised shortly. The event, originally scheduled to take place in October, has now been postponed to Friday 22 January 2021. We intend to proceed with a real-world conference at the Museum of London, followed by a drinks reception. Various contingency plans have been made to ensure that, if necessary, it can proceed remotely or part-remotely either then or at a later date. Places are limited and we expect this event to prove popular. So, please respond swiftly to the invitation to secure the best chance of reserving your place.

Annual Dinner

The viability of the annual dinner is, of course, particularly sensitive to the current state of the global and national health crisis and the prevailing Government guidance on social distancing. We have postponed the dinner, originally scheduled for June, to Friday 26 February 2021 with a view to it proceeding at the Guildhall, which is booked for that date. We intend to advertise the event in September, by which time the situation will hopefully be clearer. Full details of the terms of any commitment that a member makes by booking a place will be published at that time. However, we intend that members should not feel dissuaded by the uncertainty surrounding the various imponderables from booking a place at the dinner in the usual way; and, in the event that the dinner becomes impracticable, that there should be no financial loss to members who have booked a place. The reserves of the Association are sufficient to absorb the fixed losses that might be occasioned by a cancellation and would be used for that purpose. So, I would encourage members to look out for the notice and book up for this very popular event with your usual enthusiasm. It would be a very positive development if we were able to meet again at our annual dinner before too long.

Paul Ozin QC
23 Essex Street

Covid-19 and the Question of Legal Immunity by Richard Price OBE, QC and Rosalee Dorfman Mohajer

Richard Price OBE QC and Rosalee Dorfman Mohajer of 4-5 Gray's Inn Square discuss the question of a legal immunity for NHS workers in the Covid-19 pandemic.

What has been proposed?

The Medical Defence Union (MDU) has called for a national debate on whether health care professionals should have immunity from civil liability for actions taken in patient care in respect of the Covid-19 pandemic. It did so via an article in The Guardian newspaper on 19 April 2020[1] and a subsequent press release.[2]

In the Guardian article, the MDU explained that several states in the US, including New York, New Jersey and Michigan, have already adopted laws during the crisis that provide healthcare professionals and hospitals with immunity from civil liability for any injury or death allegedly sustained from any acts or omissions undertaken in good faith.

What is the legal immunity in New York?

After declaring a state disaster emergency in early March, New York Governor Cuomo on 23 March 2020 issued Executive Order No. 202.10. [3] This Order provided that health care workers be immune from civil liability for negligence, save for gross negligence. In the spirit of this Executive Order, the New York Legislature amended the state's Public Health Law §3082 on 2 April 2020 ("the Act"). The Act retrospectively applied to acts and omissions that occurred on or after 7 March and will continue until the declaration of the state emergency expires.

The Act is more extensive than the Executive Order as it provides immunity protection from criminal and civil liability and protects healthcare facilities, which includes nursing homes, voluntary organisations and a wider class of professionals. It covers professionals licensed or otherwise authorised by New York state law and those who provide healthcare services within the scope of the authority permitted by a COVID-19 emergency rule, which includes for example physicians and nurses licensed to practise outside of New York or without current registration, such as retirees. It also includes home care services workers.

[1] Owen Bowcott 'Union seeks legal immunity for NHS medics in pandemic' (*The Guardian*, 19/04/2020) <https://www.theguardian.com/society/2020/apr/19/coronavirus-nhs-risks-facing-billions-of-pounds-in-negligence-claims>

[2] MDU 'MDU calls for national debate over protecting NHS from COVID-19 clinical negligence claims' (*MDU,* 20/04/2020) < https://www.themdu.com/press-centre/press-releases/mdu-calls-for-national-debate-over-protecting-nhs-from-covid-19-clinical-negligence-claims>

[3] Governor Andrew Cuomo, *No. 202.10: Continuing Temporary Suspension and Modification of Laws Relating to the Disaster Emergency* (23/03/2020) < https://www.governor.ny.gov/news/no-20210-continuing-temporary-suspension-and-modification-laws-relating-disaster-emergency>

The New York statute Public Health Law §3082[4] states as follows:

"1. Notwithstanding any law to the contrary, except as provided in subdivision two of this section, any health care facility or health care professional shall have immunity from any liability, civil or criminal, for any harm or damages alleged to have been sustained as a result of an act or omission in the course of arranging for or providing health care services, if:

the health care facility or health care professional is arranging for or providing health care services pursuant to a COVID-19 emergency rule or otherwise in accordance with applicable law;

the act or omission occurs in the course of arranging for or providing health care services and the treatment of the individual is impacted by the health care facility's or health care professional's decisions or activities in response to or as a result of the COVID-19 outbreak and in support of the state's directives; and

the health care facility or health care professional is arranging for or providing health care services in good faith.

2. The immunity provided by subdivision one of this section shall not apply if the harm or damages were caused by an act or omission constituting willful or intentional criminal misconduct, gross negligence, reckless misconduct, or intentional infliction of harm by the health care facility or health care professional providing health care services, provided, however, that acts, omissions or decisions resulting from a resource or staffing shortage shall not be considered to be wilful or intentional criminal misconduct, gross negligence, reckless misconduct, or intentional infliction of harm."

The above three conditions in §3082[1][a]-[c] must be satisfied in order for the legal immunity to apply. The first requirement is that the care is arranged or provided pursuant to a COVID-19 emergency rule or otherwise in accordance with applicable law. A COVID-19 emergency rule is defined in §3081[8] and in summary is any executive order, declaration, directive or other state or federal authorisation, policy statement, rule-making or federal law that waives standards of care. The second requirement, as above, clarifies that the immunity will apply to acts or omissions taken in response to or as a result of the COVID-19 outbreak and is not limited to the care of patients with COVID-19. The third requirement is that the care must be delivered in good faith, which is in accordance with the exception to the immunity of gross negligence or the equivalent provisions, as described in §3082[2].

Why provide legal immunity?

In an article for the New York Law Journal Peter Kolbert and Caryn Lilling argue that the above actions by the New York Governor and Legislature should serve as a model for legislation to be implement across the US.[5] They submit that to promote public health, safety and welfare, hospitals and medical providers need to make treatment, staffing or resource allocation decisions during the crisis 'without concerns about the specter of future litigation.'

The MDU stated in the press release that, in the US and UK, doctors in both primary and secondary care are being asked to work in areas outside their expertise and where they may not have the most up-to-date knowledge. Retired doctors have been re-registered and asked to return to work and the final year medical students are starting work early. Routine treatments and surgeries are being delayed to cope with the influx of coronavirus patients.

The cost of medical negligence in the NHS has climbed steeply. As of 31 March 2019, NHS Resolution the accumulated claims it indemnified amounted to £83.4 billion.[6] Doctor Christine Tomkins, MDU chief executive, warned in the MDU press release that the indemnities could still cost the UK large sums of money and expose those involved in claims to 'extremely distressing' negligence allegations. She added that although they were not aware of any claims yet, they were notified of complaints arising out of Covid-19 and its effect on

[4] 'Public Health, Section 3082, Limitation of Liability' (*The New York State Senate)* < https://www.nysenate.gov/legislation/laws/PBH/3082>

[5] Peter Kolbert and Caryn Lilling, 'New York Leads the Way in Providing Liability Protections to Health Care Workers' (*The New York Law Journal,* 10/04/2020) <https://www.law.com/newyorklawjournal/2020/04/10/new-york-leads-the-way-in-providing-liability-protections-to-health-care-workers/>

[6] NHS Resolution, 'Clinical negligence numbers steady, but rising costs remain a concern' (NHS Resolution,11/07/2019), <https://resolution.nhs.uk/2019/07/11/clinical-negligence-numbers-steady-but-rising-costs-remain-a-concern/>

other services. The MDU's concern is that medical liability claims arising out of Covid-19 would be brought after the public memory of both the sacrifices made by healthcare workers and the circumstances of the pandemic which requires people to work outside their specialty and beyond their experience will be forgotten. She further argued:

"Our members are working under tremendous pressure, taking difficult decisions about patient care in very challenging conditions, and we want them to be able to do so without fear they will be unfairly judged in the months and years ahead. Doctors must be accountable for their actions but the GMC has already recognised that different considerations will need to be applied when investigating complaints.

We believe there needs to be a public debate about whether it is right to sue the NHS the patient care around the COVID-19 pandemic. Any compensation paid will be a drain on NHS resources and disastrous for the morale of staff who are acting so selflessly and courageously. Claims will also place an additional burden on taxpayers, who will be facing all the economic consequences of the pandemic. It would be better to allow the NHS to focus its time, efforts and financial resources on recovering from the pandemic".

Richard Price OBE QC
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The Chief Coroner's Guidance on Covid-19 Deaths in the Workplace by Alexandra Tampakopoulos

The Chief Coroner recently published further Guidance notes (No.37 [7]) in relation to the COVID-19 pandemic. This specifically related to deaths arising from exposure in the workplace. Within hours of its publication the Guidance had come under fire with the shadow attorney general, Lord Falconer, expressing concern that the guidance "may have an unduly restricting effect on the width of inquests arising out of Covid 19-related deaths" [8] and Rinesh Parmar, the chair of the Doctors Association UK, quoted as saying: "The provision of PPE is so vital to the safety of health workers that to suggest coroners do not consider its supply in detail misses a big part of the picture. Only comprehensive inquests into the deaths of every NHS and care worker will give the bereaved the ability to ask questions and have the circumstances of their loved ones' deaths fully explained." However, are these concerns misplaced?

The Guidance observes that the vast majority of deaths from Covid-19 will be due to the natural progression of a naturally occurring disease and so will not be referred to the coroner. However, it rightly highlights Regulation 3(1)(a) of the Notification of Deaths Regulations 2019 which provides that a doctor completing the cause of death documentation must refer a death where (s)he "suspects that the person's death was due to…(ix) an injury or disease attributable to any employment held during the person's lifetime". Therefore, there will be instances where the virus may have been contracted in the workplace and will need to be reported to the coroner. Obvious examples will be deaths of frontline NHS staff as well as care home workers, emergency service personnel, public transport employees and other key workers.

The Guidance goes on to note that it is a matter for the coroner's judgement in each case whether the facts and the evidence provide "reason to suspect" (a low threshold test) that the death was unnatural. That is, where it has resulted from the effects of a naturally occurring condition or disease process but where some human error contributed to death (R(Touche) v Inner London North Coroner [2001] QB 1206). Accordingly, the Guidance recognises, a death which is believed to be due to Covid-19 may require a coroner's investigation and inquest in some circumstances. The examples provided by the Guidance relate to failures in clinical care, failures of precautions which have caused the deceased to contract the virus which caused/contributed to the death, as well as where the

[7] https://www.judiciary.uk/wp-content/uploads/2020/04/Chief-Coroners-Guidance-No-37-28.04.20.pdf

[8] https://www.theguardian.com/society/2020/apr/29/inquests-nhs-staff-deaths-ppe-shortages

individual has died in state detention. The Guidance reminds Coroners that an inquest is not the right forum for addressing concerns about high-level government or public policy and states: "an inquest would not be a satisfactory means of deciding whether adequate general policies and arrangements were in place for provision of personal protective equipment to healthcare workers in the country or a part of it". However, this does not and should not preclude consideration of the role played by the provision or absence of PPE if this more than minimally, negligibly or trivially contributed to death.

The timing of the Guidance is perhaps unsurprising. The number of those dying at the frontline from Covid-19 is a matter of grave public concern as is the growing evidence that adequate supplies of PPE may not have been provided. We will have to see how Coroners choose to apply this guidance. As they are reminded, "Coroners make judicial decisions on a case by case basis" and "nothing in the Guidance should be taken as a statement of policy or an indication on the way that coroners should exercise their duties". Coroners are also reminded that they have a wide discretion in relation to many aspects of their investigations and inquests. If they are to put the bereaved at the heart of the process it is hard to envisage questions about PPE properly being excluded from the scope of a workplace Covid-19 death. It may well be that in due course a Public Inquiry is ordered into the apparent inadequacies in the supply of PPE to frontline workers but until that time coroners must conduct a full and fearless investigation into all matters that they have reason to suspect caused or contributed to an unnatural death.

Alexandra Tampakopoulos
2 Hare Court

The Standard of Proof of Dishonesty – Inherent Improbabilities and Evidence of Good Character: McLennan v. General Medical Council by Christopher Geering

McLennan v General Medical Council [2020] CSIH 12

Mr A brought a claim in the Employment Tribunal alleging that his employer – the Criminal Injuries Compensation Authority – was responsible for his numerous physical and mental ailments. Dr McLennan, a NHS consultant specialising in psychiatry, was instructed by the Ministry of Justice to provide an expert report into his condition. Her report was highly unfavourable to Mr A's cause – noting he had sworn freely throughout the consultation, and describing his account as inconsistent and "tinged with mendacity" (deception). It transpired, however, that Mr A had made a covert recording of the appointment which conflicted with Dr McLennan's version of the consultation in her report. In rejecting Mr A's claim, the Employment Tribunal refused to attach any weight to this recording since Mr A had elected to produce it late in the day and it had doubts over its authenticity. Subsequently, however, Mr A made a referral to the GMC. Expert evidence demonstrated that the recording had not been doctored or edited. As a result, the MPT found Dr McLennan's report was inaccurate in some 17 respects and – moreover – these discrepancies had been motivated by dishonesty on her part. She was erased from the Medical Register and appealed to the Court of Session.

The primary issue in the appeal was whether the Tribunal was entitled to make the finding of dishonesty. That involved a question about the role of evidence of good character and the inherent improbability of the appellant to have acted dishonestly. Counsel for Dr McLennan relied on the inherent unlikelihood that she would have acted in a dishonest manner, which the Tribunal did not engage with adequately. It was more probable any inaccuracy was the result of an honest mistake rather than a deliberate falsehood. It was unlikely that she would have "periled" her career for the sake of this report. Why would she? In this regard the appellant placed significant weight on the wealth of character evidence provided. In addition, she attacked the quality of the reasons produced by the Tribunal to justify its decision. The Court of Sessions dealt with these arguments robustly, rejecting each in turn.

Inherent unlikelihood

The court found no assistance could be drawn from the "inherent unlikelihood" argument. Once it had been established that Mr A had not said what Dr McLennan had reported him as having said, the question, consistent with Ivey v. Genting Casinos (UK) Ltd [2018] AC 391, could be simply addressed as being whether the

appellant knew that what she was reporting was not true. If that were the case, there would be only one inference that an ordinary decent person could draw. The Court of Session observed:

"[T]here ought to be cogent evidence before dishonesty is found… However, the use of such axiomatic language does not detract from the general legal proposition that the test to be applied in determining whether a crucial fact, including dishonesty, is to be found remains the balance of probabilities… In approaching the exercise of deciding the critical issue, a Tribunal should keep an open mind, untinged by any preconceived general notions that dishonesty is less likely than not to have occurred or that it is inherently improbable, especially when the person accused is one of good repute." [emphasis added]

The extent to which the courts consider the concept of inherent unlikelihood a helpful gloss to the standard of proof is controversial. Nonetheless, it is fair to say this decision struck a particularly strident tone. It rejected the whole concept. In doing so, it conflicted with numerous authorities. When the Tribunal in Okpara v General Medical Council [2019] EWHC 2624 (Admin) summarised the position in this way, for example, the High Court endorsed it as an "impeccable direction":

"[W]e must also have in mind… to whatever extent is appropriate in this case is that the more serious the allegation, the less likely it is to have occurred, and, hence, the stronger the evidence should be before we conclude that the allegation is proved on the balance of probabilities. The more serious the allegation, the more cogent is the evidence required to overcome the unlikelihood of what is alleged and thus to prove it."

Surely, the Court of Sessions' view went too far. In R (N) v Mental Health Review Tribunal (Northern Region) [2006] QB 468 the court put it well when it observed:

"Situations which make such heightened examination necessary may be the inherent unlikelihood of the occurrence taking place… if it is alleged that a bank manager has committed a minor peculation, that could entail very serious consequences for his career, so making it the less likely that he would risk doing such a thing. These are all matters of ordinary experience, requiring the application of good sense on the part of those who have to decide such issues."

The bank manager's peculation and Dr McLennan's inaccurate report are on the same page. Both are inherently unlikely. Any evidence must be considered with that fact in mind. It is a matter of common sense that people are less likely to risk throwing away reputation, career and their profession for nothing.

Character evidence

The Court of Session was equally unimpressed by the wealth of character evidence relied on by Dr McLennan. It said that the degree to which evidence of good character may be significant will vary according to the facts and circumstances of the particular case. Some caution is required before giving it too much weight:

"The inquiry by a Tribunal into an allegedly dishonest act or other misconduct will, or at least should, focus on the act itself. The Tribunal will look primarily at the evidence which bears directly on whether or not the act occurred. It is important for a Tribunal not to be deflected from that task by delving too deeply into an individual's professional or personal background. Although that individual may well be able to secure testimonials to his or her good character from amongst his or her close associates, it is unlikely that the opposing party, who is attempting to prove the allegation, will have either the time, resources or ability to delve into the individual's past in an attempt either simply to refute the terms of such references or to secure evidence of a less than perfect past."

The court applied the same logic to bad character evidence. It observed, again, the focus should be on the act itself, and not on such evidence "even if it had a direct bearing on whether the individual had a "propensity" to act in the manner alleged, that is not relevant to proof of the particular act." It went on to add that:

"As a generality, those pursuing disciplinary proceedings should not be permitted to introduce evidence of general bad character as an element in the proof of dishonesty on a specific occasion. They are not to be encouraged to ingather evidence of bad character either to refute the terms of references, which might be, or have been, produced, or as an attempt to undermine either credibility or reliability. If it were to be otherwise, tribunal hearings would be greatly prolonged, and the tribunal could be deflected from its purpose, by parties addressing matters of peripheral, if any, significance. Although it may be legitimate to establish that an individual has no previous disciplinary record, since that is a matter which is usually readily

ascertainable, there must be practical constraints on the extent to which a tribunal should otherwise permit evidence of either general good or bad character, when that character is not the gravamen of the complaint." [emphasis added]

Again, the court appears to have taken a more strident approach to the issue of character evidence. The approach of the Court of Session fits uncomfortably with cases like Donkin v Law Society [2007] EWHC 414 (Admin) where no criticism was made of the voluminous highly impressive character references produced to rebut any suggestion of dishonesty. Character currently forms an important element of any professional's defence to an allegation of dishonesty. Surely, that is right. Cogent evidence of good character may well render it less likely – on the balance of probabilities – that a doctor acted dishonestly in a particular instance. In the same vein, if bad character evidence can be adduced against a doctor – without undue risk of satellite litigation delaying matters – surely such evidence is relevant and admissible? A person who acts dishonestly in similar circumstances is more likely to do so in the future.

Reasons

As to the quality of the reasons expected of a Tribunal, on the facts the court by a majority considered these were adequate in the instant case. It was not possible to categorise the Tribunal's finding of dishonesty as plainly wrong, and in relation to each of the 17 items in Dr McLennan's report the Tribunal explained the reason for its decision on the particular discrepancy.

Christopher Geering
2 Hare Court

The Role of the General Medical Council and the Boundaries of Professional Conduct, Talk to South London and Maudsley NHS Foundation Trust by Kenneth Hamer

I should first like to thank Dr Priyo Ghosh, Consultant Psychiatrist, North Lambeth Promoting Recovery Team, South London and Maudsley NHS Foundation Trust for inviting me to give this talk, and Lambeth Hospital for the arrangements and making possible for it to be given remotely by Microsoft Teams.

I realise that I am addressing a group of distinguished psychiatrists and those with considerable expertise of working in mental health. When sitting as a judge in the Crown Court I often read reports and heard evidence from psychiatrists and made a number of hospital orders under the Mental Health Act 1983 in the case of mentally disordered persons. I was always fearful that the expert who was giving evidence may have thought that it was I who should be certified under the legislation! They were always too kind to suggest anything like that and I was always grateful for the help I unfailingly received. So it is with great pleasure that I come to talk to you today.

The subject of my talk is: The Role of the General Medical Council and the Boundaries of Professional Conduct. In expressing my views in this talk, let me say straightaway that they are my personal views, and should not be taken as necessarily those of any regulator or other body.

The General Medical Council (GMC) is a statutory body that takes its rise from and can trace its history back to the Medical Act 1858.

Medical Act 1858

The 1858 Act was passed to regulate the qualifications of practitioners in medicine and surgery. It brought together the disciplinary processes of the Royal College of Physicians that was chartered in 1518, the College of Surgeons established in 1745, and other medical bodies such as the Society of Apothecaries. It provided for the establishment of the General Council of Medical Education and Registration in the United Kingdom, the predecessor of the GMC.

The Royal College of Psychiatrists has existed in various forms since 1841, having started life as the Association of Medical Officers of Asylums and Hospitals for the Insane. In 1865 it became the Medico-Psychological Association. In 1926, the Association received its Royal Charter, becoming the Royal Medico-Psychological Association. Finally, in 1971, a Supplemental Charter accorded the Association the status of the Royal College of Psychiatrists. Today, the College stands alongside the other great Royal Colleges of medicine in providing, amongst other things, medical research and public information about mental health problems in society. The public should be grateful to it.

The Medical Act 1983, as amended, is today's

overarching statute for the medical profession.

Medical Act 1983

Section 1 sets out the GMC's objectives.

"1A. The over-arching objective of the General Council in exercising their functions is the protection of the public.

1B. The pursuit by the General Council of their over-arching objectives involves the pursuit of the following objectives – (a) to protect, promote and maintain the health, safety and well-being of the public, (b) to promote and maintain public confidence in the medical profession, and (c) to promote and maintain proper professional standards and conduct for members of that profession.

3. The General Council shall have the following committees – (g) the Medical Practitioners Tribunal Service, (h) one or more Medical Practitioners Tribunals."

Under sub-section 3, you will see reference to the Medical Practitioners Tribunal Service (MPTS), which operates through one or more Medical Practitioners Tribunals. That is where I come in as a chairman of the Tribunal, sitting with at least one doctor and a lay member. The MPTS is the only body that can erase, suspend or impose conditions on a doctor's right to practise medicine. Whilst one reads in the press about cases coming before the Tribunal, and the case of Dr Bawa-Garba is perhaps the most recent one that received huge public attention as well as concern expressed by many in the medical profession, it is important to put matters into context. The overwhelming majority of doctors will rarely, if ever during their professional career, receive a letter of complaint from the GMC raising concerns about their behaviour, and the number of cases in any year that end up before the Tribunal is small.

The GMC's Annual Report 2018 is the most recent and it gives details of the numbers of licensed doctors and the outcome of cases heard by the Tribunal.

GMC Annual Report 2018

Number of licenced doctors at 31 December 2018. UK 165,945, total 250,210.

- In 2028, the GMC reviewed a total of 8,573 concerns. Of these concerns 6,629 overall were closed, 1,544 met the statutory threshold for investigation into the doctor's fitness to practise, and 394 were referred to the doctor's employer.
- Outcomes from 1,208 decisions by case examiners. 700 concluded with no further action, 228 with warnings, advice or undertakings, and 280 referred to MPTS.
- Outcomes from MPTS fitness to practise panels. 247 outcomes – 41 no impairment, 25 conditions, 10 warnings, 101 suspended, 65 erased, 2 impaired but no further action, 3 voluntary erasure.

So much for the legislation and the role of the GMC.

Let me turn now to the difficult area of fitness to practise and how the MPTS goes about its business.

Section 35C of the Medical Act 1983 sets out the circumstances whereby a doctor's fitness to practise may be regarded as impaired. It is quite a long list and includes a finding against the medical practitioner of misconduct, which must amount to serious professional misconduct; deficient professional performance; a criminal conviction or caution; adverse physical or mental health; not having the necessary knowledge of English; or a determination by another healthcare body, such as the General Dental Council. An allegation may be based on events having occurred both within and outside the United Kingdom or at a time when the practitioner was not registered.

The decision as to whether a doctor's fitness to practise is currently impaired is made at the hearing and, as we have seen, only a small proportion of cases go before the Tribunal and many are concluded with less draconian orders than suspension or erasure, which are reserved for the most serious cases. In 2014 the Law Commission reported on the Regulation of Health Care Professionals.[9] In their report they recommended that misconduct as a ground on which to determine whether a person's fitness to practise is impaired should be reclassified as "disgraceful misconduct", whilst at the same time proposing greater emphasis should be placed on the concept of deficient professional performance as a ground of regulatory intervention. That, to my mind, is a sensible way forward so as to ensure a more holistic approach to cases concerning a doctor's fitness to practise.

[9] *Regulation of Health Care Professionals; Regulation of Social Care Professionals in England*, LC No 345. In October 2017, the

There is no doubt that over time the concept of "misconduct" has expanded. In her Fifth Shipman Report, Dame Janet Smith described the difficulties that have been experienced over the years in defining and recognizing the concept of professional misconduct and noted that the problem had become more acute over the years.[10] As Dame Janet said in her report, until the 1990s the GMC was mainly concerned with cases of misconduct involving dishonesty, drug abuse, indecency, improper relationships with patients and breach of confidence. In effect, the GMC was concerned with deliberate or reckless misconduct, and did not generally concern itself with wider allegations such as negligent treatment of a patient or the many and varied complaints of professional misconduct received today by the GMC and other health care regulators.

The same has happened in the legal profession. Writing in 2010 in the Law Society's Gazette, my colleague Gregory Treverton-Jones QC asked rhetorically where to draw the line? He said:

"Time was, not very long ago, when a visitor to the Solicitors Disciplinary Tribunal would be presented with a diet of thefts from client account, serious Accounts Rules breaches, or solicitors for one reason or another could no longer run their practices. Today, the same visitor might well see decent, bewildered, and sometimes angry solicitors being hauled before the SDT. For generations of solicitors, the answer to ethical dilemmas was straightforward – if it felt wrong, it probably was wrong. Always put your client's best interests first. Never take unfair advantage. Don't put yourself in a position where your interests conflict with those of your clients. Never knowingly mislead anyone. And, above all, never, ever, dip into client account to smooth out your practice's cashflow problems."

Returning to the GMC, the current guidance on what is expected of a doctor is set out in Good Medical Practice (GMP). The latest edition was published by the GMC in March 2013 and was updated in April 2019.

Good Medical Practice

GMP is the GMC's core guidance for all registered doctors. It is a code of conduct and can be downloaded from the GMC's website www.gmc-uk.org. It is worth re-reading in full.

As you will see, the duties of a doctor registered with the GMC are fairly extensive. They cover:

- Knowledge, skills and performance, which means making the care of your patient your first concern and providing a good standard of practice and care.
- Safety and quality, which means taking prompt action if you think that patient safety, dignity or comfort is being compromised, and protecting the health of patients and the public.
- Communication, partnership and teamwork, which means treating patients as individuals and respect for their dignity, working in partnership with patients and working with colleagues in the ways that best serve patients' interests, and
- Maintaining Trust which means being honest and open and acting with integrity, never discriminating unfairly and never abusing your patient's trust or the public's trust in the profession.

It is said that on arriving in Chambers in the 1950s, a young barrister was told by their supervisor, then called a pupil master, to go and read the Code of Conduct of the Bar of England and Wales, adding that it was the only law book with which they need be concerned. My advice is that if you follow Good Medical Practice, hopefully you will be all right.

A particular problem that sometimes arises is where a doctor is called upon to express an opinion or act outside his or her expertise. The GMC has issued a joint statement with the statutory health and care regulators on issues arising from the coronavirus (Covid-19) pandemic.[11] The case of Dr Squier, a consultant paediatric neuropathologist at the John Radcliffe Hospital in Oxford is more a case in point.[12] The core of Dr Squier's ordinary practice was the analysis of samples of brain tissue taken from both the living and the dead. Additionally, she had developed a medico-legal practice, providing reports as an expert neuropathologist. Between 2007 and 2010 she provided reports and gave evidence in the case of six babies, of whom five had died shortly after allegedly sustaining

Government published a consultation paper which included many of the Law Commission's recommendations.

[10] *Fifth Shipman Report – Safeguarding Patients: Lesson from the Past – Proposals for the Future,* by Dame Janet Smith DBE, Command Paper Cm 6394.

[11] https://www.gmc-uk.org/news/news-archive/how-we-will-continue-to-regulate-in-light-of-novel-coronavirus

[12] *Squier v. General Medical Council* [2016] EWHC 2739 (Admin).

non-accidental head injuries. In those cases she had unfortunately expressed opinions that were outside her expertise and had made assertions that were insufficiently founded on the evidence before her, and she had purported to rely on research papers that did not support her opinions in the way she suggested. In allowing Dr Squier's appeal against the Tribunal's sanction of erasure, the High Court said that it was not in the public interest that the public at large should be deprived of her work merely because she had, in one discrete area of her practice, fallen below the standards required of her. The appropriate sanction was the imposition of conditions for 3 years preventing her from providing medico-legal reports in court cases outside her ordinary practice.

The court there clearly took a charitable view of the need to ensure the continued good services of an experienced doctor. A couple of other cases of interest. Dr Southall was a consultant paediatrician although the circumstances of the case could equally have applied to a consultant psychiatrist.[13] He was instructed as an expert on behalf of a local authority to give a medical opinion concerning a child's death. Following an interview with the mother, M, she complained to the General Medical Council that he had accused her of murdering her son. That allegation, amongst others, was considered by a fitness to practise panel, which found that Dr Southall had made that accusation. The Court of Appeal, in allowing Dr Southall's appeal, said that the panel's reasons for preferring the mother's account of the interview were inadequate. Although entitled to conclude that the mother was an honest and credible witness, the panel did not specifically deal with the suggestion that she perceived herself to be accused, which may be entirely understandable in the circumstances but was wrong.

On the other hand, in Dzikowski v. GMC, a consultant psychiatrist was charged with prescribing a methadone mixture to a patient in circumstances that were inappropriate, irresponsible, and not in the best interests of his patient.[14] His defence that the Department of Health's publication entitled "Drug Misuse and Dependence: Guidelines on Clinical Management" was a recommendation, and not an instruction, and that he was justified in his deviation from it was held not to be a valid defence. The Orange Book, as it was called, was important guidance and should have been followed. Dr Dzikowski was aware of it and the evidence was clear that he ignored it when treating his patient.

These cases show that each case is fact sensitive and the outcome may ultimately depend on a narrow understanding and appreciation of the facts in any case.

Let me end with two cases, which both attracted wide public attention. Each concerned a child who tragically died. One is the case of Dr Bawa- Garba.[15] But first let me tell you about the notorious case of Alfie Winn.[16] 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 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 was reported in the press and led to questions in Parliament. As a result the GMC's then guidance 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.

Dr Hadiza Bawa-Garba faced criminal proceedings of gross negligence manslaughter resulting from the death of a child. In February 2011, Dr Bawa-Garba was a junior doctor specialising in paediatrics and had recently returned to practise as a registrar at Leicester Royal Infirmary following maternity leave. Jack Adcock, a six year old boy, was on the morning of Friday 18 February 2011 admitted to the hospital by his GP as an urgent referral, arriving at the hospital unresponsive and limp. Jack had been diagnosed from birth with Downs Syndrome and required long-term medication and in the past had been admitted to hospital for pneumonia. For the following 8 – 9 hours he was under the care of Dr Bawa-Garba and was treated initially for acute

[13] *Southall v. General Medical Council* [2010] EWCA Civ 407.
[14] [2009] EWHC 1090 (Admin).
[15] *Bawa-Garba v. General Medical Council* [2018] EWCA Civ 1879.
[16] Fifth Shipman Report, Dame Janet Smith DBE.

gastro-enteritis and dehydration, and then after an x-ray for a chest infection with antibiotics. In fact 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. Dr Bawa-Garba was charged with gross negligent manslaughter and was found guilty and sentenced to 2 years imprisonment suspended for 2 years. Her appeal against conviction and sentence was dismissed by the Court of Appeal, Criminal Division. The trial judge in his sentencing remarks said that there was a limit to how far the circumstances in which the offence took place and that the children's unit where Dr Bawa-Garba was working at the time was a busy ward could be explored in a criminal trial, although there may be force in the argument that her responsibility was shared with others.

The role of the criminal courts is very different to that of the Tribunal in professional conduct proceedings. The task of the jury is to decide on the guilt or absence of guilt of the defendant having regard to their past conduct. The task of the Tribunal, looking to the future, is to decide what sanction would most appropriately meet the statutory objectives of the regulator.[17] This aspect was explored further in the subsequent fitness to practise proceedings in Dr Bawa-Garba's case and figured extensively in the Tribunal's determinations on impairment and sanction. The Tribunal found that her actions marked a serious departure from GMP but there were also multiple systemic failures by the Trust and other failings including an absence of a mechanism for an automatic consultant review. The Tribunal suspended Dr Bawa-Garba's registration for 12 months. As is well known, that decision was reversed by the High Court who directed that Dr Bawa-Garba should be erased from the medical register. The Court of Appeal later restored the suspension and remitted the case to the MPTS who imposed conditions on Dr Bawa-Garba's registration.

These cases, therefore, are a stark reminder of how difficult it is to judge the outcome of fitness to practise proceedings and that each case turns on its own facts. However, the themes are clear. The Medical Act 1983 sets out today's overarching objective of the GMC which is the protection of the public. Many complaints either fall away or involve no further action or are referred for disposal at local level to the doctor's employer. The number of cases that are determined in any year by the Medical Practitioners Tribunal Service involve a minority of professionals when compared to the number of doctors in practice in the United Kingdom. The Tribunal is concerned with the reputation or standing of the profession rather than any punishment of the doctor, although a sanction may have a punitive effect . Finally, Good Medical Practice is a key document that sets out the standards and core responsibilities that are expected to be followed by every doctor. And I am sure we can all agree that the system for the investigation and determination of complaints must be just, fair and transparent both for the good of the public and the medical profession.

I hope that this talk will have given you a better understanding of the role of the GMC and the boundaries of professional conduct.

Thank you.

Kenneth Hamer
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Legal Update

Beard v. General Osteopathic Council [2019] EWHC 1561 (Admin)

Bias - interventions by committee – excessive questioning by panel member of registrant - failure of committee to be even handed – proceedings rendered unfair and irretrievably compromised

B, a registered osteopath, appealed against the findings of the respondent's Professional Conduct Committee upholding a charge of unacceptable professional conduct arising from two consultations with a patient in July 2016, and imposing conditions of practice on her registration for a period of 12 months. The allegations found proved included that B did not conduct an adequate assessment of Patient A's foot; did not provide a diagnosis; did not discuss or explain the treatment to him or why it was appropriate; used excessive force on his foot when treating him; and communicating inappropriately and unprofessionally with him when responding to emails from him. Despite B's detailed notes there were disputes about what

[17] [2018] EWCA Civ 1879 at paragraph 76.

happened during the sessions, and Patient A wrote long and opinionated emails and letters to B complaining of the quality of the treatment provided and her professional conduct. Kerr J described Patient A's correspondence as aggressive, inappropriate, and bullying in its tone and content, and expressed concern that the committee's questioning of B treated the correspondence as if it were normal. The principal ground of appeal asserted apparent bias and unfairness arising from the conduct of the hearing and in particular from questions asked by one of the panel members. The committee asked well over 200 questions, described by the judge as an "inquisition", which lasted longer than the case presenter's cross-examination who had already put the case fully, competently, and fairly. In contrast Patient A was asked almost nothing by the committee in a case where credibility was likely to be decisive of the case. In addition to a transcript of the proceedings the judge had a digital tape recording of the hearing and listened to those parts of the tape recording relevant to the appeal. After referring to Yuill v. Yuill [1945] 1 All ER 183, CA; Jones v. National Coal Board [1957] 2 QB 55; Galea v. Galea (1990) 19 NSWLR 263; and Demarco Almeida v. Opportunity Equity Partners Ltd [2006] UKPC 44, Kerr J said the court in Galea set out six propositions subsequently cited by the Privy Council in Demarco Almedia when considering the fairness of a judge's conduct. The six propositions are, paraphrased by Kerr J:

1. The test is whether excessive intervention or pejorative comment created a real danger that the trial was unfair.
2. There is greater latitude towards judicial intervention where the judge sits alone than when sitting with a jury.
3. On appeal, the issue is whether the interventions indicate that a fair trial has been denied because the judge has closed his or her mind to further persuasion, moved into counsel's shoes and "into the perils of self-persuasion".
4. Whether the point of unfairness has been reached must be considered in the context of the whole trial and in the light of the number, length, terms and circumstances of the judge's interventions. Interventions suggesting a provisional view must be distinguished from those suggesting a final unalterable view.
5. The point at which the interventions occur is relevant; vigorous interventions early in the trial are less readily excused than one at a later stage aimed at permitting the judge better to comprehend the issues and weigh the evidence of the witness concerned.
6. The general rules for conduct of a trial and the respective functions of judge and advocate have not changed; but a more active judicial role in proceedings than formerly is now accepted; sometimes a silent judge may cause injustice by not alerting a party to issues concerning the judge.

The learned judge said that in Banerjee v. General Medical Council [2017] EWCA Civ 78, where the Court of Appeal upheld Walker J's decision that the panel had not conducted the hearing unfairly by reason of its questions, the court accepted the parties' common position that the applicable principles were to be found in Demarco Almeida. The Court of Appeal did not say the applicable principles were different because of any qualitative difference between the nature of a disciplinary tribunal's jurisdiction and that of a court of law trying a civil claim. However, the facts of Banerjee were completely different from those in the present case. In Banerjee, the advocate representing the GMC had not cross-examined the doctor at all on the point that was troubling the panel. In the present case, by contrast, there was no gap in the evidence, as there was in Banerjee. It is undoubtedly correct that the bar is set high, and the court will not lightly find that the questioning of a witness has compromised the fairness of the proceedings and rendered the decision unjust. However, the questioning of B in the present case was of particular importance and centrality to the case, because of the stark conflict between her evidence and that of Patient A. The court would expect particular care to ensure an even handed approach to their respective accounts. The factual context must be considered. It was obviously inappropriate and wrong for Patient A to express himself in the way he did. The panel member's lengthy questions about B's reaction to the correspondence, and the tone in which the questions were asked, contributed substantially to B's distress without throwing any new or further light on the issues the committee had to decide. The decision of

the committee was unjust because of a serious procedural or other irregularity, namely the questioning by the panel member which was unfair and rendered the proceedings unfair. The chairman's intervention and questions afterwards did not cure the unfairness of the proceedings, which were irretrievably compromised. The respondent should hesitate long and consider carefully whether it is appropriate to refer the same allegations to a differently constituted committee.

R (Stone and ors) v. Police Misconduct Tribunal and ors [2020] EWHC 385 (Admin)

Bias - legally qualified chair – prejudicial material sent to chair – application for recusal refused by tribunal – panel comprising legally qualified chair, police officer and magistrate – application for judicial review – alternative remedy – no apparent bias by chair – legally qualified chair able to disregard irrelevant evidence

The claimants were six police officers who faced serious allegations of gross misconduct arising from the detention and restraint of a suspect who later died. There were no allegations that the officers caused and/or contributed to the death of the suspect or that their treatment of him was in a different manner due to his ethnicity or race. The misconduct hearing arose from an investigation by the Independent Office for Police Conduct who directed misconduct proceedings pursuant to para 27(4) of schedule 3 of the Police Reform Act 2002. Prior to the hearing a large number of unredacted documents were sent to the chair pursuant to regulation 21(1)(c) of the Police Conduct Regulations 2012. The documents included the IOPC report, a bundle of medical evidence, witness statements and a report of the chief inspector which the claimants contended contained highly prejudicial material which should not have been put before the chair. The claimants believed that material had been provided which was irrelevant and inadmissible. An application for recusal was in due course refused by the whole tribunal with written reasons. The claimants sought judicial review. Dismissing the claim, Saini J said that the claimants had an alternative remedy. The Police Appeals Tribunals Rules 2012 included a designated avenue of appeal to the Police Appeals Tribunal and the availability of a statutory process which includes an appeal process was, on the facts of this particular case, fatal to this claim. The case of R (Squier) v. General Medical Council [2015] EWHC 299 (Admin) was a case on special facts, as identified in the judgment of Ouseley J at para 22. Dealing with the alleged apparent bias, Saini J, at [73] – [96], said that when deciding whether the tribunal was right not to recuse itself, it is not for the court to assess the tribunal's reasons on some form of Wednesbury or rationality basis. Rather it was appropriate for the court to decide (as the hypothetical fair minded and informed observer) and on the basis of the same materials as were before the tribunal/chair whether they/he should have recused themselves; see AWG Group Limited v. Morrison [2006] EWCA Civ 6, [2006] 1 WLR 1163, per Mummery LJ at [19]-[20]. Having read the material in respect of which complaint was made, Saini J said that it was clear that opinions were expressed by a number of people (with varying degrees of emphasis), and that those opinions did on occasion go into areas where there were no allegations of misconduct against the claimant officers. The core bundle for the tribunal now did not include this material. However, even when it was obvious that a tribunal had seen prejudicial material, there is no absolute rule that such material is fatal to the fairness of the proceedings; see R (Mahfouz) v. Professional Conduct Committee of the GMC [2004] EWCA Civ 233, and Subramanian v. General Medical Council [2003] UKPC 64. The nature of the tribunal is relevant. The position of the tribunal in this case is directly analogous to that of the panels in Mahfouz and Subramanian. The chair is a legally qualified non-practising solicitor who, for many years, sat as a judge; one member of the tribunal is an experienced magistrate, the other an experienced police officer; and everyone of them was well-placed to identify and ignore irrelevant and inadmissible material.

R (Kuzmin) v. General Medical Council [2019] EWHC 2129 (Admin), [2019] 1 WLR 6660

Evidence – failure to give evidence – adverse inference – procedural irregularity – whether fair to draw adverse inference from failure to give evidence

The claimant was a registered medical practitioner. Disciplinary proceedings against him were brought before a panel of the MPTS in which an allegation of

dishonesty was made. At the close of the GMC's case, following an unsuccessful application to have the case dismissed, the claimant withdrew his witness statement and indicated that he would not give evidence before the tribunal. The GMC sought a ruling from the tribunal that, as a matter of principle, it had the power to draw an adverse inference from the fact that a doctor against whom charges are made does not give evidence. After hearing submissions on that issue, the tribunal concluded that it had that power. The claimant challenged that decision. The Divisional Court (Hickinbottom LJ with whom Butcher J agreed) said, at [31], that inferences are merely conclusions deduced by a competent fact-finder by a process of reasoning (including drawing on common experience) from primary facts, i.e. matters which the fact-finder accepts were observed by witnesses and proved by oral or written testimony, or proved by the production of a thing itself such as an original document. However, inferences may be impermissible in certain circumstances, notably where they give rise to procedural unfairness or an unacceptable risk of such unfairness. After reviewing, among others, Wisniewski v. Central Manchester Health Authority [1998] PIQR P324, R (Panjawani) v. Royal Pharmaceutical Society of Great Britain [2002] EWHC 1127 (Admin), Iqbal v. Solicitors Authority [2012] EWHC 3251 (Admin), Radeke v. General Dental Council [2015] EWHC 778 (Admin) and Kearsey v. Nursing and Midwifery Council [2016] EWHC 1603 (Admin), Hickinbottom LJ said, at [57] – [63], that in his view, both principle and authority favour the proposition that disciplinary tribunals have the legal power to draw adverse inferences from the silence of an individual charged with breaches of the regulatory scheme to which he or she is subject, even if in practice they have not in the past drawn such inferences in individual cases. It is open to a tribunal to draw adverse inferences from the failure of a charged registered medical practitioner to give evidence, including, in an appropriate case, the inference that he has no innocent explanation for the prima facie case against him, subject to such an inference not being procedurally unfair. Whether an adverse inference is drawn will be highly dependent upon the facts of the particular case, and generally no inference should be drawn unless:

i. a prima facie case to answer has been established;
ii. the individual has been given appropriate notice and an appropriate warning that, if he does not give evidence, then such an inference may be drawn; and an opportunity to explain why it would not be reasonable for him to give evidence and, if it is found that he has no reasonable explanation, an opportunity to give evidence;
iii. there is no reasonable explanation for him not giving evidence; and
iv. there are no other circumstances in the particular case which would make it unfair to draw such an inference.

Professional Standards Authority v. Nursing and Midwifery Council and Lembethe; and Professional Standards Authority v. Nursing and Midwifery Council and Mkhize [2019] EWHC 3326 (Admin)

Evidence - late disclosure by regulator of crucial email – whether panel erred in refusing to admit evidence – prejudice to registrant to be balanced against public interest in admitting evidence

Ms Lembethe (L) was the deputy manager at a nursing home where Ms Mkhize (M) began working as a staff nurse on 14 February 2017. The panel heard the cases against the registrants together. It was alleged that L dishonestly produced and signed a certificate of in-house Basic Life Support dated 25 January 2017 which M dishonestly sought to rely on by submitting it to a nursing agency in January 2017, i.e. before the date when she had begun working at the nursing home. During the NMC's case it emerged that M had sent an email to the agency on 27 January 2017 with the certificate attached. The panel accepted that the email was relevant but refused to admit it on the grounds of fairness to the registrants. Accordingly, the panel found not proved the allegations of dishonesty against each registrant. In allowing the PSA's appeal that the panel erred in refusing to admit in evidence the email attaching the certificate, Steyn J said that the question whether it is fair to admit evidence is an issue of law, to be judged objectively by the court, rather than by reference to whether the decision of the panel was a reasonable exercise of its discretion: see R (Squier) v. General Medical Council [2015] EWHC 299 (Admin) at

[23]. In the instant case, the email was not merely relevant. It was crucial (and potentially conclusive) evidence on the central question before the panel, namely, whether the certificate was submitted to the agency in January 2017. It would be unfair to admit the email without giving the registrants time to consider and address it, including by obtaining expert evidence if they wished. The panel was advised they should give particular weight to fairness to the registrants. In giving this advice, the legal assessor did not mention that, first and foremost, the function of the NMC is to protect, promote and maintain the health and safety of the public. Nor did the legal assessor advise the panel of the need to balance fairness to the registrants against the important public interest in the panel reaching a correct determination on the charges of dishonesty. The panel failed to give due weight to the public interest or to balance it against such prejudice to the registrants as would have arisen if the email had been admitted and they had been given time to consider and address it.

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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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