Neutral Citation Number: [2021] EWHC 681 (Admin)

Case No: CO/4856/2020

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 24/03/2021

Before :

MR JUSTICE MOSTYN

- -

Between :

EMMANUEL TOWUAGHANTSE	**Appellant**
- and -	
GENERAL MEDICAL COUNCIL	**Respondent**

- -
- -

Alan Jenkins (**Direct Access**) for the **Appellant**
Alexis Hearnden (instructed by **GMC Legal**) for the **Respondent**

Hearing date: 16 March 2021

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Approved Judgment

Mr Justice Mostyn:

1. On 21 October 2013 Patient A was born in hospital at Carlisle. From antenatal scans it was known that he had developed an exomphalus[1] major. This is an extremely rare and disturbing condition occurring in about one in 4,000 births. In all pregnancies the intestine initially develops inside the umbilical cord. Normally, after a few weeks it moves inside the abdomen. However, in these rare cases the intestine, and sometimes other organs such as the liver, develop outside the abdomen within a membrane. Exomphalos major describes the condition where the size of the defect is greater than 5-cm in diameter.

2. Needless to say, exomphalus major is a serious condition which requires prompt treatment after birth. I cite the website of the Great Ormond Street Hospital for Children:

> "Depending on the size of the exomphalos, the infant may need to have it repaired in one operation or in several stages. If the exomphalos is small and the child is stable, they may have an operation soon after transfer, where the surgeon replaces the contents back inside the abdomen and closes up the base of the umbilical cord.
>
> If the exomphalos is larger, contains the liver and/or the child needs to be stabilised, doctors may place a silo or pouch over the intestines, which is closed over a period of days to weeks, to allow the child to grow so that there is room inside the abdomen."

3. A dangerous potential side-effect of an operation for immediate replacement of the viscera within the abdomen - known as a primary closure procedure - is the development of Abdominal Compartment Syndrome ("ACS"). ACS occurs when tissue fluid within the abdomen accumulates in such large volumes that the abdominal wall struggles to stretch to accommodate it. When this compression occurs in such a small space organs begin to collapse under the pressure. When the abdomen can no longer be distended then without very prompt surgery the patient will likely die.

4. It had been planned that Patient A would be born at the Royal Victoria Infirmary in Newcastle ("RVI"), but he arrived early (at 37 weeks) and so was born in Carlisle. The exomphalus was observed to be quite large and contained most of the bowel and a large part of the liver. Patient A had some difficulty breathing and was intubated. He was immediately transferred to the RVI.

5. On 21 October 2013 the appellant, a consultant paediatric surgeon, was working as a locum at the RVI. He was 58 years old. He qualified as a doctor in 1978 overseas. He obtained his Fellowship of the Royal College of Surgeons (FRCS) in General Surgery in 1985 and his FRCS in Paediatric Surgery from the Royal College of Surgeons in 2000. He had enjoyed a career without blemish. The testimonials produced on his behalf all speak of his professional competence.

[1] The etymology of which is ἐξ out + ὄμφαλος navel.

6. Patient A was stable on arrival at the RVI but required to be ventilated. He was referred by the Paediatric Intensive Care Unit (PICU) to the appellant, the on-call paediatric surgeon, who assessed Patient A at 17:15. He made the decision to undertake a primary closure procedure the following day.

7. The developing tragedy is described in the formal determination of the facts made by the Medical Practitioners Tribunal ("MPT"), seven years later on 16 November 2020[2]:

> 1. On 21 October 2013, following your examination of Patient A [at 17:15], you failed to discuss either your management plan with the senior paediatric surgical colleagues with regard to the management of Patient A or the timing of any surgery (if it was deemed necessary).
>
> And you failed personally to obtain informed consent from Patient A's parents in that you failed to discuss:
>
> - the various options available for Patient A's management (including (a) delayed primary closure; (b) delayed closure using an artificial patch; (c) primary closure with patch for the muscle and possible primary skin cover; and (d) removal of exomphalos sac and application of a Silo);
> - the procedure involved with a primary closure; and
> - possible complications/risks of the operation.
>
> 2. Your decision to carry out a primary closure procedure on Patient A [on 22 October 2013 at about 15:30] was inappropriate given Patient A's age and weight; and the size of the exomphalos major.
>
> 3. *(not proved)*
>
> 4. At the conclusion of Patient A's first operation [at about 17:30]:
>
> - you failed to pay attention to the concerns being raised by the anaesthetic staff whilst Patient A remained on the operating table;
> - you failed to consider altering your management plan; and
> - you failed to remain with Patient A to ensure that there was no suggestion of Abdominal Compartment Syndrome ('ACS').

[2] I have lightly edited the language and punctuation of the formal determination to enable an easier reading of it.

5. Following Patient A's first operation:

- you failed to pay attention to the monitoring results of the urine output and other parameters conveyed to you by staff in the Paediatric Intensive Care Unit;
- you failed to reconsider your management plan, given the information you were being provided with regard to Patient A's condition;
- you failed to pay attention to the concerns being raised by the medical staff who were caring for Patient A;
- you failed to take Patient A back to the theatre, despite indications that Patient A had increased pressure in his abdomen;
- you failed to recognise the serious signs that Patient A was exhibiting; and
- you failed to consider that Patient A may have been suffering from ACS.

6. On 23 October 2013 following Patient A's second operation [at about 08:00], you failed to remain with Patient A given his critical condition at that time.

7. Your record keeping in respect of your involvement in Patient A's care was inadequate, in that:

- it failed to make reference to the fact that you were asked to return to the operating theatre on two occasions;
- it failed to make reference to serious concerns that were raised with you by the anaesthetist; and
- it failed to make reference to serious clinical signs that Patient A was displaying.

8. Your actions and omissions as set out at paragraphs 1 to 7 contributed to the death of Patient A [on 23 October 2013 at about 19:40], who had a treatable condition."

These formal, unemotional words do not convey the distress suffered not only by the parents, but also by members of staff of the RVI, who witnessed the unfolding tragedy which led to the baby dying in his mother's arms that evening shortly after 19:40.

8. The findings constitute very severe criticism of the appellant not only for his inexplicable decision to attempt, on the presented facts, an inappropriate primary closure procedure. The findings also criticise him severely for his even more

inexplicable inaction in the six hour window following the first operation. In that period there was insistent concern expressed to him by nursing and medical staff that the baby was suffering perilously from ACS and needed to be re-operated on immediately. Had that action been taken by the appellant before midnight on 22 October 2013 the baby could have been saved. But he did not act. He did not do so until 08:00 the following morning by which time it was too late. By then the baby's bowel was dying, if not already dead, and his fate was tragically sealed.

9. The written evidence of the GMC's main expert witness, Mr Alizai said this:

> "Although, I maintain that the primary closure for patient A was the incorrect decision, considering the size of the defect and the size of the baby, but an even greater negligence by Mr E Towuaghantse happened during the post-operative period. Even if the closure was a tight closure, for which there is no doubt that it was, had Mr E Towuaghantse listened to what all the other clinicians were telling him or if he had assessed and considered all possibilities for patient A's post-operative condition and had opened the abdomen in the intensive care unit or by bringing him back to the operating theatre within the first 3 to 4 hour period following closure, patient A's viscera would probably have survived, with some damage. In other words the lack of reasonable post-operative management was even more relevant in this case and proper action taken at that stage would have negated an earlier wrong action taken by Mr E Towuaghantse. Even if the tribunal decides that the decision to primarily close patient A's abdomen was not seriously below what is expected of a reasonably competent consultant paediatric surgeon, although I still believe it was, there is absolutely no defence for Mr E Towuaghantse to not have opened Patient A's abdomen in a timely manner, to avoid continuing damage to his viscera and organs. There were clear unremitting, non-defensible signs of increased intra-abdominal pressure, which no reasonably trained consultant paediatric surgeon will deny or attribute to lack of fluids."

10. The factual findings made on 16 November 2020 were rendered after 15 days of proceedings before the MPT. On 18 November 2020 the MPT concluded that the factual findings amounted to misconduct and that the appellant's fitness to practise was currently impaired by reason of such misconduct.

11. The appellant was allowed to continue to work after 23 October 2013 by virtue of a series of seven MPT interim orders starting on 4 March 2014, which limited him, bizarrely, to NHS paediatric work (but not the repair of any exomphalus). From that date until late 2015 the conditions meant that he could not find work and indeed in that year he was made bankrupt. However, on 8 January 2016 all restrictions were revoked. They were not re-imposed following the findings against him made by a Coroner at an inquest on 5-8 March 2018. Since early 2016 he has been working as an abdominal surgeon (on adults) without any criticism being made of his professional fitness to do so.

12. The initial interim order dated 4 March 2014 and the four following orders ending on 24 November 2015 all contained the following statement (or words to the same effect):

> "[The panel] is satisfied that these allegations of professional misconduct, if proven, are serious matters which may pose a real risk to patients and could adversely affect public confidence in the profession. It considered that a reasonably and properly informed member of the public would be surprised if Dr Towuaghantse was permitted to return to practise without restriction at this time. After balancing Dr Towuaghantse's interests and the interests of the public, an interim order remains necessary to guard against such a risk.
>
> Whilst the panel notes that the order has restricted Dr Towuaghantse's ability to practise medicine it is satisfied that the order imposed is the proportionate response. The panel considers that an interim order of conditions will protect the public and the wider public interest whilst permitting him to continue in clinical practice. The panel considers that an order of conditions remains proportionate, appropriate and workable and will manage the risks identified concerning his management of this rare congenital anomaly."

13. The final order, made on 9 July 2018, following receipt of Mr Alizai's first report and the Coroner's findings (see below) stated:

> "In reaching its decision, the Tribunal has borne in mind the serious concerns raised in relation to Dr Towuaghantse's management, care and treatment of Patient A, a new born baby, who subsequently died. The Tribunal has noted that this case involves a single clinical incident, involving the uncommon condition of exomphalos major, which took place over 4.5 years ago. It has noted that no similar or other clinical concerns have been raised either before or since the alleged incident.
>
> Furthermore, the Tribunal has noted that Dr Towuaghantse has been working in a non-consultant grade post for some time, with no concerns raised, and has stated he does not intend to seek or undertake paediatric surgical posts in the future.
>
> In all the circumstances the Tribunal considers that there is no information before it today to suggest that Dr Towuaghantse may pose any real current risk to patient safety. Furthermore, while the Tribunal has noted both the Coroner's narrative conclusion and the GMC expert report, it considers that given the long passage of time with no additional concerns raised, a reasonable and well informed member of the public would not be surprised to learn that Dr Towuaghantse had been permitted to remain in unrestricted clinical work pending the conclusion of the GMC investigation. The Tribunal has therefore

> determined to place no order on Dr Towuaghantse's registration."

14. How did the MPT on 18 November 2020 reach the conclusion that his current fitness to practise was impaired? It concluded that the appellant's conduct between 21 and 23 October 2013 had put Patient A at unwarranted risk of harm which resulted in his avoidable death; it had brought the profession into disrepute; and it had breached fundamental tenets of the profession namely the provisions of Good Medical Practice and the Consent Guidance. How did that past conduct translate into current impairment? In its impairment finding the MPT held at [31]:

> "Having listened to Mr Towuaghantse's submissions and evidence, the Tribunal concluded there is little evidence to suggest that he has come to a full understanding and acceptance of what caused the tragic outcome insofar as Patient A was concerned. In particular, Mr Towuaghantse failed to accept any of the Coroner's findings. He sought to blame others for what had occurred. That was the case even at the impairment stage in his assertion that his efforts at remediation were thwarted by other staff at the RVI not wishing to work with him. In the judgment of the Tribunal, his expressions of regret and his admission that there were errors fall very far short of what would be required to demonstrate insight in the circumstances of this case. The Tribunal determined that Mr Towuaghantse's insight is limited at best."

15. The MPT went on to find that the outcome of this terrible incident was of the most serious kind and that the failings of the appellant were significant, substantial and not easily remediable. It found that the extent and gravity of the appellant's failures would cause widespread public concern thereby undermining public confidence in the profession, and, further, that his conduct was a significant deviation from what the public are entitled to expect of medical practitioners. Therefore, notwithstanding that the events in question had occurred seven years previously, and that in that period the appellant had been working as a medical practitioner with the sanction of the MPT, a finding of current impairment against the appellant was necessary in order to maintain proper professional standards and conduct.

16. On 20 November 2020 the MPT turned to the question of sanction. It concluded in this phase that the appellant's insight and remediation remained incomplete: he had not demonstrated a full understanding of the failures intrinsic to his decision to carry out the first operation or the failures that led him to decline to take Patient A back to theatre, notwithstanding the concerns raised by colleagues and the obvious adverse signs that the baby was exhibiting. It considered mitigating factors namely that this was a singular incident and that the appellant had never before or since been found to be impaired. He had kept his skills up to date. He had apologised to the baby's parents at the hearing and had done so earlier. It considered that the main aggravating factor was that the appellant had fundamentally failed to provide an adequate level of care. The MPT concluded that this aggravating factor "must be accorded considerable weight notwithstanding, in particular, the passage of time since 2013".

17. The MPT rejected the imposition of conditions. Because of the serious nature of the findings these would not be appropriate or proportionate or in the public interest; nor, (in contrast to the view of the MPTs which made the interim orders) would conditions be workable, given the appellant's limited insight. The MPT rejected the sanction of suspension concluding that it would not be sufficient to protect the public, maintain public confidence and promote and maintain professional standards and conduct. The MPT specifically held at para 56 that in the absence of evidence of full remediation there remained a risk of repetition; there was a risk to patient safety because of the lack of timely insight and the lack of full remediation.

18. The MPT further held at para 57:

> "Whilst it has found that there is an ongoing risk to patient safety, it also considered that the gravity of the misconduct is such that erasure would remain the appropriate sanction even if there was no ongoing risk to patient safety. In this respect, the Tribunal also had regard to paragraph 108 of the SG which provides that:
>
> > 108. Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards designed to protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor."

19. An order for erasure was therefore made. Such an order does entitle the registrant to apply to be restored to the register after five years. However, at his age of 65 it is not realistic to think that he would succeed in demonstrating that he had kept all his skills up-to-date in that period. Realistically, this order amounts to a permanent erasure.

20. I will consider the reasoning that led to the sanction of erasure in further detail later in this judgment.

21. The appellant appeals against this determination of the MPT. He is entitled to do so, without leave, pursuant to section 40 of the Medical Act 1983 ("the 1983 Act"). CPR 52.21(3) provides that an appeal may be allowed where the decision of the first instance court was either (a) wrong or (b) unjust because of a serious procedural or other irregularity in those proceedings. CPR PD 52D para 19(b) provides that an appeal under section 40 of the 1983 Act shall be by way of rehearing. However, the distinction between a rehearing and a review on such an appeal is one without a difference: see *Kirschner v The General Dental Council* [2015] EWHC 1377 (Admin) at [8].

22. The grounds of appeal allege both wrongness and procedural irregularity. One ground was abandoned at the commencement of the hearing. Another was abandoned in Mr Jenkins's final submissions. The active grounds which I have to consider are as follows:

> 1. The General Medical Council relied on irrelevant, prejudicial and inadmissible material during the factual stage of the case. It produced the written conclusions of the Coroner who had presided at an inquest into the death of Patient A, and who had heard evidence from a number of witnesses.
>
> 2. The GMC relied upon an expert witness, described as Dr N in the determinations, but who was not independent. He had worked at the hospital in Newcastle where Patient A was treated, and he knew and had worked with key witnesses appearing for the GMC. His evidence should not have been given any weight.
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> 3. *abandoned in Mr Jenkins's final submissions*
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> 4. The GMC failed to produce antenatal medical records concerning discussions between Patient A's parents and medical staff prior to the hearing. This was notwithstanding that the Appellant was being criticised for not personally discussing the case with the parents prior to operating on the child. When antenatal records were produced within the hearing, they were incomplete, and the Appellant was thereby prejudiced in his defence.
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> 5. *abandoned at start of appeal*
>
> 6. The finding of impairment and the imposition of the sanction of erasure were unfair in all the circumstances, and in particular the Tribunal failed to give proper consideration to the facts that:
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> a. the relevant events occurred in 2013, so more than 7 years before the hearing;
>
> b. the Appellant had recognised at an early stage that he had made errors in the case and shown insight: he had apologised to Patient A's parents at the inquest, and which he repeated before and during the hearing;
>
> c. the Appellant's practice over that 7 year period was unblemished, and he had not undertaken any paediatric work.

Ground 1

23. An inquest into the death of Patient A took place between 5 and 8 March 2018. It has not been explained to me why it took 4½ years for this to happen. True, there was a police investigation. But even allowing for that, the delay is extraordinary. It is not reasonable for key witnesses to be expected to keep alive in their memories details of crucial events after such a passage of time.

24. The Coroner recorded a narrative verdict. This comprised findings of fact, which occupied 2½ pages of text and a narrative conclusion which occupied less than half a

page of text. The appellant does not dispute the admissibility of the findings of fact. He does dispute the admissibility of the narrative conclusion. This identified three specific failures by the appellant which "directly contributed to the death". This narrative conclusion was included in the bundle before the MPT; no objection to its inclusion was taken by the appellant at any of the case management hearings prior to the final hearing. Although the appellant acted as a litigant in person at the final hearing he was represented by Mr Jenkins at the case management hearings.

25. In *Barnett v Cohen* [1921] 2 KB 461, McCardie J held, under the law of evidence then in force, that the depositions of the evidence given in a Coroner's inquisition together with the verdict and rider of the jury were not admissible in evidence in an action under Lord Campbell's Act 1846 by the personal representatives of an infant as proof of the defendant's negligence. That decision was cited in the well-known case of *Hollington v F Hewthorn & Co* [1943] KB 587, CA. In his judgment Goddard LJ held that under the then law of evidence a conviction for careless driving was inadmissible in a later negligence action. He justified his conclusion by reference to two principles. First, by reference to the "best evidence rule". Second, in the negligence action the status of the criminal conviction was no more than an irrelevant, non-expert, and therefore inadmissible, opinion of the criminal court as to culpability.

26. The rule against the admissibility of criminal convictions in civil proceedings was abrogated by s.11 of the Civil Evidence Act 1968. Where did that leave other civil judgments or coronial verdicts? Were they admissible in later proceedings? In *Land Securities Plc v Westminster City Counci*l [1993] 1 WLR 286 Lord Hoffmann explained that the "best evidence rule" was a disguised reference to the rule against hearsay; that rule was abrogated by s.1 of the Civil Evidence Act 1995, which made all hearsay evidence admissible. In *Masquerade Music Ltd v Springsteen* [2001] EWCA Civ 563 at [85] Jonathan Parker LJ stated that the "best evidence rule, long on its deathbed, has finally expired". So, the admission of civil judgments or coronial verdicts could not be opposed on that basis.

27. However, the second of Goddard LJ's principles has not been explicitly overtaken by modern developments in the law of evidence. Goddard LJ explained it thus (at 595):

> "It frequently happens that a bystander has a complete and full view of an accident. It is beyond question that, while he may inform the court of everything that he saw, he may not express any opinion on whether either or both of the parties were negligent. The reason commonly assigned is that this is the precise question the court has to decide, but, in truth, it is because his opinion is not relevant. Any fact that he can prove is relevant, but his opinion is not. The well recognized exception in the case of scientific or expert witnesses depends on considerations which, for present purposes, are immaterial. So, on the trial of the issue in the civil court, the opinion of the criminal court is equally irrelevant."

28. In *Hoyle v Rogers & Anor* [2014] EWCA Civ 257, [2015] 1 QB 265, a case about the admissibility of an Air Accident Investigation Branch report in a negligence action, Christo0pher Clarke LJ held at [32] – [40] (in observations which were obiter dicta in

relation to the admissibility of previous judgments) that the rule in *Hollington v F Hewthorn & Co* lived on. He cited the passage above, and then held at [39]:

> "As the judge rightly recognised the foundation on which the rule must now rest is that findings of fact made by another decision maker are not to be admitted in a subsequent trial because the decision at that trial is to be made by the judge appointed to hear it ("the trial judge"), and not another. The trial judge must decide the case for himself on the evidence that he receives, and in the light of the submissions on that evidence made to him. To admit evidence of the findings of fact of another person, however distinguished, and however thorough and competent his examination of the issues may have been, risks the decision being made, at least in part, on evidence other than that which the trial judge has heard and in reliance on the opinion of someone who is neither the relevant decision maker nor an expert in any relevant discipline, of which decision making is not one. The opinion of someone who is not the trial judge is, therefore, as a matter of law, irrelevant and not one to which he ought to have regard."

29. For the reasons I set out below, I do not have to grapple with the question whether this principle (which I will call the relevancy principle), is correct and binding. If it is correct then I would observe that the following statement by the authors of Jervis on Coroners (14th edition) at [20-10] may not be right:

> "Not only the evidence, but also the determination and findings, at an inquest may be helpful in civil proceedings. Importantly, the inquest findings and conclusion are not binding on any other court and cannot be relied upon to establish liability in a civil claim … the evidence heard at the inquest, and the findings and conclusion, may be of interest and assistance in relation to disciplinary or fitness to practise proceedings, or to other investigations."

30. The reason I do not have to grasp the nettle is that the rule has long been held not to apply to inquisitorial proceedings. For example, it does not apply to family proceedings, whether about children or money, where the court is obliged by statute to take into account all the circumstances of the case: see *Re H (A Minor) (Adoption: Non-patrial)* [1982] Fam 121, *Richardson-Ruhan v Ruhan* [2017] EWHC 2739 (Fam), [2018] 1 FCR 720 at [12] – [13].

31. Regulatory proceedings of the type with which I am concerned are quintessentially inquisitorial. So, the rule does not apply to them. This is put beyond doubt by the General Medical Council (Fitness to Practise) Rules Order of Council 2004 (SI 2004 No. 2608), r.34(1) which provides that:

> "The Committee or a Tribunal may admit any evidence they consider fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law".

32. The receipt of strictly inadmissible material in regulatory proceedings goes back a long way. In *General Medical Council v Spackman* [1943] AC 627, HL the House of Lords confirmed that in disciplinary proceedings alleging "infamous conduct" against a doctor – adultery – the GMC was entitled to regard a divorce decree, which had found that the doctor had committed adultery as co-respondent, as prima facie proof of that adultery. Viscount Simon LC emphasised that strict rules of evidence did not apply, stating at 636:

> "[The GMC] is not required to conduct itself as a court. Its members may usefully bear in mind the language of Lord Loreburn LC in *Board of Education v. Rice* [1911] AC 179, 182, where, dealing with the decision of an administrative body the Lord Chancellor said that 'they must act in good faith and fairly listen to both sides, for that is the duty lying upon everyone who decides anything. But I do not think they are bound to treat such a question as though it were a trial … They can obtain information in any way they think best, always giving a fair opportunity to those who are parties in the controversy for correcting or contradicting any relevant statement prejudicial to their view.'"

33. In *R (on the application of Squier) v General Medical Council* [2015] EWHC 299 (Admin) the issue was the admissibility in disciplinary proceedings of a number of previous judgments of the High Court and the Court of Appeal (Criminal Division) in which the registrant had been severely criticised as an expert witness. Ouseley J cited the cases mentioned above and held at [43] – [48] (which merit citation in full):

> "43. There is not so great a divide between *Hoyle v Rogers* and *Spackman* and the more recent disciplinary cases where the issues, parties and evidence are different. The present case however is not one in which a particular relevant issue was decided in proceedings to which the registrant was a represented party, as arose in *Spackman*. The crucial point about the role of the disciplinary tribunal is that it should be the decision maker on the issues and evidence before it; it should not adopt the decision of another body, even of several judges, as a substitute for reaching its own decision on the evidence before it, on the different issues before it. None of that precludes the GMC under its Fitness to Practice Rules considering the judgments in a case in which evidence later at issue before the GMC was given. But they are not relevant for the purposes of substituting one judgment for the other, because it is the FTPP's statutory duty to decide the issues before it. The issues before it are not those which were before the courts, and the evidence and parties are also different. It may also be unfair for the judgments to be a significant influence on the mind of the tribunal on the crucial issues before it for those same reasons. *Constantinides* strikes an important note of warning.
>
> 44. But the purpose of admitting the judgments here is not to substitute one judgment, or several, for the judgment of the

FTPP or even to treat those judgments as rebuttable prima facie evidence of the correctness of the allegations which the FTPP is to decide. The avowed basis for their admission may not go as far as perhaps it could have done in the authority of Spackman. To the extent that the judgments were taken as prima facie proof of any fact relied on, they would be rebuttable, and would have to be weighed against the evidence called by Dr Squier.

45. It is not unfair for the judgments to be admitted, for the same reasons. The FTPP must find for itself the facts necessary to reach a conclusion on the quality of the expert evidence given by Dr Squier in the light of the allegations as to its shortcomings, and the evidence before the FTPP. The FTPP should be very careful to avoid any actual or inferred findings of the judges on the quality of Dr Squier's evidence being used as evidence of the truth of the allegations, because that risks substituting another body for its functions. And its task is not that of the judges in those cases; the issues crucially are different, as are the parties and the evidence which it will have to consider.

46. The balance struck by the FTPP between the probative value of the judgments and any prejudicial effect is reasonable. The material is potentially relevant and the judgments here are clearly not peripheral. Moreover the specific findings have been redacted so there is less of it available to require Dr Squier to devote time and energy to dealing with findings as opposed to focussing on the quality or otherwise of her evidence, to which the allegations relate. That has also reduced the prospect of the judgments being used for an irrelevant or unfair purpose. It is less likely, if not impossible, for the findings on the matters of importance for the FTPP's own task to be resolved by the judgments. Although the fact that Dr Squier was not a party meant that she could not necessarily deal with criticisms in the court proceedings, and some were clearly put to her, she can deal with them before the FTPP.

47. The proof of whether the judgments are in reality irrelevant or used for an irrelevant purpose will be shown by the FTPP's ultimate decision on the allegations. It is not for this court and not for a court now at this stage to anticipate that possibly irrelevant or unfair use might be made of the judgments, and to rule that the FTPP decision on admissibility is therefore wrong in law. The purpose for which its admission is sought is neither irrelevant nor to make unfair use of it. The opportunity for irrelevant or unfair use is markedly reduced by the redactions. Dr Squier still has the opportunity to say that any particular passage or finding of fact would be unfair and to seek to have it removed. That is an opportunity she has not yet taken up. It is by no means an inevitability or even the likely outcome of the

> admission of the evidence that irrelevant or unfair use would be made of it. But if it is, the decision will be appealable on that ground.
>
> 48. I do not accept the submission that the admission of the judgments would reverse the burden of proof. The judgments, as redacted, do not include findings on the allegations which it is for the FTPP to decide. They provide background, context and proof of what I would expect to be often non-contentious matters. The FTPP has to find the allegation proved by the GMC on the evidence that the scope and content of Dr Squier's expert evidence was below the standard required of an expert; the allegations are not that the evidence was wrong, or rejected by the judges. Dr Squier can explain how she would have dealt with any aspects seen as critical in the judgments, but they are not the focus of the case and the redactions have essentially been sufficient to prevent that or at least to prevent it in any significant degree. It is inevitable that the FTPP will know or infer, whatever happens, that her evidence was not accepted and that there were criticisms of its quality."

34. This impeccable analysis should be followed by me. It confirms that the relevancy principle does not apply to inquisitorial regulatory proceedings. The Coroner's narrative conclusion in this case was thus plainly admissible, and was rightly admitted. It was weighed with all the other evidence in determining the facts. But the MTP must not have made unfair use of the Coroner's narrative conclusion. Were it to have done so, then its decision would be appealable. In my judgment para 47 of Mr Justice Ouseley's judgment is very important.

35. My decision on Ground 1 is that the Coroner's narrative conclusion was plainly admissible in all three phases of the proceedings (facts, impairment and sanction). The MTP rightly held that it was not bound by the findings of the Coroner. However, as set out above in para 14, in the impairment phase the MTP held that there was little evidence to suggest that the appellant had come to a full understanding and acceptance of what caused the tragic outcome, in particular by failing to accept any of the Coroner's findings. As explained above, that finding of a lack of insight and understanding was a key component in the finding of a limited capacity to remediate, which in turn critically informed the decision on impairment, which in turn strongly influenced the decision on sanction. I will explain below that when it came to sanction the appellant was not treated fairly inasmuch as his defence of his conduct both before the Coroner and before the MTP was used against him as evidence of incapacity to remediate. Therefore, it will be seen in my decision on Ground 6 that the Coroner's narrative conclusion was unfairly used against the appellant when it came to impairment and sanction. Ground 1 therefore fails in its primary end, namely that the material is inadmissible, but will partially succeed when the fairness of the decision-making process in relation to impairment and sanction is considered under Ground 6.

Ground 2

36. In regulatory proceedings of this type there are no procedural rules regulating the adducing of expert evidence. To adduce expert evidence you do not need permission.

A party does not need to prove that it would "reasonably assist" the resolution of the proceedings, let alone that it is "necessary" for that purpose (as CPR 35.1 and FPR 25.4 respectively require). There is no limit on how many reports an expert witness may file. It seems to be an old-fashioned free-for-all.

37. In this case the GMC relied on the written and oral expert evidence of Mr Naved Alizai, a consultant paediatric surgeon. He produced no fewer than five reports: 22 May 2017, 8 March 2019, 14 October 2020, 26 October 2020, and 30 October 2020. He also gave oral evidence. It is certainly true that the language that he uses in his report is not the measured, temperate, moderate and balanced prose that one is accustomed to reading from an expert witness. On the contrary, his language is colourful, rhetorical, intemperate and unrestrained. It certainly made for interesting reading. The reason, as the witness candidly accepts, for the strength of his language is because he feels so strongly that the appellant was guilty of gross professional misconduct.

38. The appellant relies on the strength of Mr Alizai's opinion as evidence that he was plainly guilty of actual bias. He also alleges apparent bias. He argues through his counsel, Mr Jenkins, that as practitioners in the same field they had met each other, corresponded, and even competed for jobs. Further, Mr Alizai had completed some of his training at the RVI, and knew several of the consultants who were key factual witnesses. Thus it was said by Mr Jenkins:

> "it was, or should have been, obvious to the witness, the respondent and to the tribunal that the witness could not fairly be said to be independent or objective in his evidence".

39. The question of the independence of the expert witness was raised before the MPT which ruled:

> "The Tribunal considered the question of conflict and determined, without hesitation, that there was no conflict of interest in Mr Alizai's case. Having heard his evidence, read his various reports and considered the case in the generality, there is nothing to support the proposition that he was affected by bias, whether real or apparent."

40. In my judgment this short ruling is unimpeachable. In *Hopkinson v Hickton, sub nom Re Maximus Securities Ltd* [2016] EWCA Civ 1057 the appellant was a minority shareholder in the fourth respondent company (MSL). A Tomlin order was made which compromised an unfair prejudice petition brought by the appellant in relation to MSL's affairs. Under a schedule to that order, the fifth respondent (MGL) agreed to purchase the appellant's shares in MSL at their open market value in September 2010. MSL's only asset was a piece of land and in order to determine the value of the appellant's shares, the schedule provided for the valuation of the land by an 'independent valuer'. A valuer was jointly instructed by the parties. When accepting the appointment he indicated that he had no conflicts of interest. However, his valuation report referred to the fact that he had overseen, but not personally undertaken, a valuation of the land in 2013. He indicated that he had only become aware of that when he received the respondents' written submissions on valuation. The appellant contended that the expert was not an 'independent valuer'; the judge

disagreed. Patten LJ held that the judge had been right to apply the high test of apparent bias in assessing whether the valuer had been independent at the date of his appointment. This was because his opinion would be determinative. An expert witness, or independent valuer, is not automatically disqualified from giving expert evidence by reason of some relationship with one of the parties or even an interest in the outcome of the proceedings. That was a matter for the judge to assess having regard to the relevant circumstances.

41. On the facts of this case, I cannot say that the MPT's approach in applying the tests of actual and apparent bias to the appellant's application to disqualify Mr Alizai for want of independence, was materially wrong. Given the critical importance of his evidence, which was likely to be highly influential, if not determinative, it was right (or at least not wrong) that this high test was applied. Actual bias is confined to the position where it is shown that the expert has a direct personal interest in the outcome of the proceedings which is other than de minimis. Apparent bias will be found to exist where the reviewing court or tribunal, attributing to the reasonable man knowledge of the relevant circumstances and adopting a broad approach, assesses on behalf of that reasonable man that there is a real danger of bias.

42. I am fully satisfied that the MPT rendered a correct ruling in response to the challenge by the appellant to the independence of Mr Alizai. The strength of his feeling does not betray the existence of a direct personal interest in the outcome. There was thus no basis to find that there existed actual bias. As for apparent bias, it was inevitable that the appellant and the witness would know each other; the pool of paediatric surgeons in this country is small and there is much common acquaintanceship. The fact that Mr Alizai knew some of the consultants at the RVI is neither here nor there. Nor is the fact that he did some of his training there. The MPT was right to conclude that there was no real danger of actual bias.

43. Ground 2 is therefore dismissed.

Ground 4.

44. One of the allegations found proved against the appellant was that he failed to discuss with the parents the various options available for Patient A's management. The appellant believed that the antenatal notes of Patient A's mother would show that the options for the treatment of the baby were fully discussed with her.

45. In Mr Jenkins's skeleton he put it this way:

> "The Respondent omitted the antenatal notes for Patient A from the material placed before the Tribunal. The notes were essential for the Tribunal's understanding of the discussions between Patient A's parents and the paediatric surgeon Mr Lall, and decisions made prior to Patient A's delivery. (The Appellant was working as a locum, employed for six months to replace Mr Lall.) When the Appellant produced two documents (from images on his mobile phone, and which he had obtained at the time of the inquest into the death) from antenatal clinic appointments with Mr Lall, the GMC obtained antenatal

> records, but which were incomplete. There was no letter to the GP to reflect the discussions at those appointments.
>
> The absence of this letter was a significant handicap to the Appellant, who was accused of failing to discuss the case with the parents. Earlier discussions with the parents, conducted by Mr Lall, were important in any consideration of the Appellant's alleged failings and the seriousness of them."

46. The notes include an antenatal care history sheet which has a record for 4 June 2013 when the baby's mother met Mr Lall, the paediatric surgeon. The note records that there was a discussion regarding exomphalus major; the mode of delivery; the operative and non-operative management options depending on the surgeon's view and the size/type/contents of the exomphalus; the long-term sequelae including a long hospital stay with ventilatory support for months; the need for staged surgery; and the possibility of associated chromosomal disability. There is a stamp suggesting that a letter had been sent relating to this consultation (although the date on the stamp is probably incorrect – it says 3 June 2013) but there is no letter on the file either to the mother or the GP (and there are letters about other matters to the GP on the file). Hence the belief that a key document has not been produced.

47. It is noteworthy that no application was made for disclosure of antenatal notes prior to the commencement of the final hearing. The matter was only raised during the hearing and the GMC agreed to produce what it could. On Day 10 more than 200 pages of notes were produced. The appellant maintained that this was not a complete record, for the reasons set out above.

48. The tribunal had made a ruling on 30 October 2020 (Day 5) refusing the appellant's application that Dr Lall and the mother's obstetrician make witness statements. It invited the GMC to produce a full run of antenatal notes but made it clear that the proceedings would not be adjourned while those documents were being obtained and observed that such matters of case management should have been dealt with earlier. As stated above, the notes were produced on Day 10. The appellant did not seek a halt to the proceedings on the ground that the notes were incomplete. Neither did he seek to recall any witness in the light of the contents of those notes.

49. The MPT plainly considered that the notes, while having some potential relevance, did not in fact throw any light on a matter in issue. The supposed missing letter from Dr Lall to the GP would not have added anything to the content of the advice that he gave, which was duly recorded in the note.

50. In my judgment the MPT dealt with this issue entirely correctly. Specifically, I agree that production of a letter incorporating Dr Lall's advice given orally on 4 June 2013 (if it existed) would not have thrown any further light on the contested allegation that the appellant failed to discuss with the baby's parents the options for his management. Further, this aspect of the appellant's conduct did not specifically feature in the impairment decision (see paras 27 - 36) although it was taken into account generally for that purpose as misconduct (see para 27). I am not satisfied that if the missing letter in fact existed and had been produced it would have made any difference to that process of reasoning.

51. Ground 4 is therefore dismissed.

Ground 6

52. Once an MPT has determined the facts it then determines impairment and sanction. These are dealt with in separate phases although they are, in truth, conjoined. There cannot be a sanction unless the registrant's current fitness to practise has been found to be impaired. A concrete factual finding will not normally have any evaluative component, although in this case para 2 of the allegations charged the appellant with an "inappropriate" decision to carry out a primary closure procedure. The use of that adjective required this MPT in its fact-finding to make, in that regard, an evaluative or judgemental decision. The MPT did not get drawn into a full evaluative analysis at this point but rightly, in my opinion, interpreted the adjective "inappropriate" to mean "contraindicated" (see para 60 of the decision on the facts). That aside, the exercise in relation to the fact-finding was to decide whether or not things happened.

53. However, when it came to the impairment phase the exercise was almost entirely evaluative. The sanctions phase was a mixture of evaluation and, potentially, the exercise of discretion. The main sanctions decision, namely whether to erase, is plainly evaluative (see *Bawa-Garba v The General Medical Council & Ors* [2018] EWCA Civ 1879 at [60]). Had the decision been, however, to suspend, or to impose conditions, then the length of suspension, or the nature and terms of conditions, would have been discretionary.

54. When the GMC, acting through an MPT in disciplinary proceedings, exercises its evaluative and discretionary functions it is fixed with the over-arching objective of the protection of the public (see section 1(1A) Medical Act 1983). Section 1(1B) states that pursuit of that over-arching objective involves the pursuit of three objectives namely:

    i) protecting, promoting and maintaining the health, safety and well-being of the public;

    ii) promoting and maintaining public confidence in the medical profession; and

    iii) promoting and maintaining proper professional standards and conduct for members of that profession.

55. Therefore, when exercising its disciplinary functions, the overarching objective of an MPT is the protection of the public. Accordingly, a sanctions decision is not penal. Rather, it is from first to last motivated only by the need to protect the public in the sense spelt out above. As stated above, the decision is not narrowly confined to protecting the health and safety of the public. It extends to maintaining public confidence in the reputation of the medical profession and the need to promote and maintain high professional standards and conduct of its members. Thus, in *General Medical Council v Meadow* [2006] EWCA Civ 1390 [2007] 1 QB 462 Sir Anthony Clarke MR stated at para.32:

> "The purpose of FTP proceedings is not to punish the practitioner for past misdoings but to protect the public against the acts and omissions of those who are not fit to practise. The

> FPP thus looks forward not back. However, in order to form a view as to the fitness of a person to practise today, it is evident that it will have to take account of the way in which the person concerned has acted or failed to act in the past."

56. The presence of the second and third objectives means, as the MPT correctly found, that there may be some cases where even though the registrant poses no current risk to the public, it is necessary, in order to promote one or other or both of them, for the registrant to suffer an order for erasure. And that this was such a case. The imposition of the ultimate sanction for a singular historic transgression in order to set an example recalls Voltaire's aphorism in 1759 that it is from time to time necessary to do so "pour encourager les autres."

57. An evaluative judgment formed after hearing oral evidence is especially difficult to challenge on appeal: *Biogen Inc v. Medeva Plc* [1996] UKHL 18 per Lord Hoffmann at [54], *Beacon Insurance Company Ltd v Maharaj Bookstore Ltd* [2014] UKPC 21 per Lord Hodge at [16] to [17]. The need for appellate caution is further enhanced where the decision has been made by a specialist tribunal: *Bawa-Garba* at [67]. When exercising its sanction powers the MPT will, naturally, have regard to the Sanctions Guidance. However, the Guidance is only guidance. It provides signposts to a possible destination rather than a fixed track leading to an inevitable terminus. This much is clear from *Bawa-Garba* at [83] where the Lord Chief Justice stated:

> "The Sanctions Guidance contains very useful guidance to help provide consistency in approach and outcome in MPTs and should always be consulted by them but, at the end of the day, it is no more than that, non-statutory guidance, the relevance and application of which will always depend on the precise circumstances of the particular case."

58. I have explained above how the findings about the insight of the appellant, and his capacity to remediate, were central to the finding of current impairment of fitness to practise. These findings not only opened the door to sanctions but were also carried over into the decision on sanction.

59. I have set out above at para 14 an extract from para 31 of the impairment decision. I draw attention to the sentence: "**In particular**, **Mr Towuaghantse failed to accept any of the Coroner's findings**" (my emphasis).

60. In similar vein in para 32 of the sanctions decision the MPT said this:

> "The Tribunal noted Mr Towuaghantse's change of stance as the hearing progressed. There was more evidence of insight provided at the sanction stage than at the preceding ones in that Mr Towuaghantse had placed more emphasis on his own failings than before. However it could not ignore the fact that, particularly at the first stage of the hearing when the Tribunal was considering the facts, Mr Towuaghantse had tried to attribute to others at least some of the responsibility for what had happened to Patient A. **In the judgment of the Tribunal,**

> **that was a particularly regrettable feature of the case**." (my emphasis)

61. It is clear to me that a significant component in the decision-making process, both as to determination of impairment of fitness to practise, and in the imposition of the sanction of erasure, was the conclusion that the appellant was to be seriously faulted for (a) having contested the allegations against him at the inquest, and not having accepted the Coroner's findings, and (b) having contested the allegations against him at the MPT. The pleas of not guilty (in effect) in both courts were clearly regarded by the MPT as evidence of an incapacity to remediate and therefore of a risk to the public, as well as an aggravating feature contributing to the award of the ultimate penalty.

62. At para 56 of the sanctions decision the MPT said "in the absence of evidence of remediation there remains a risk of repetition." The "absence of evidence" referred to must have included the forensic stance of the appellant in defending the allegations against him both at the inquest and before the MPT[3].

63. In my judgment it is not procedurally fair for a registrant to face the risk of enhanced sanctions by virtue of having robustly defended allegations made against him before the MPT, or before another court.

64. In *Misra v. General Medical Council (GMC)* [2003] UKPC 7 charges were brought which included an allegation that the registrant had lied in his response to the initial complaint made to the GMC. Lord Scott deprecated this practice. He stated at [17]:

> "Their Lordships find the inclusion in the charge of allegations that Dr Misra gave information he knew to be untrue rather puzzling. The substantive allegations against Dr Misra were that he had been informed of each of the four telephone calls and requests for home visits. Dr Misra had admitted being informed of only two of them. So there was a substantive issue as to whether he had been informed of the other two. If he were to maintain his denial at the hearing and be believed that would be an end of the issue. If his denial were to be disbelieved then the Committee would have to consider his conduct regarding Mrs Berryman on the footing that he had received four requests to visit her but had failed to do so and on the footing also that he had lied on oath about two of the telephone calls. What the GMC's point was in adding to the charge first an allegation that he had earlier told the same lie to Mr Berryman and secondly that the lie had been repeated in his solicitor's letter to the GMC is not clear. Their Lordships enquired of Mr Greene, counsel for the GMC, whether it was a general GMC practice where

[3] I would add that the reference to "an absence of evidence" might suggest that the burden of proof at the impairment stage had been switched from the GMC to the appellant. It might suggest that the MPT was requiring the appellant to prove that he had fully remediated, rather than requiring the GMC to prove that he had not. However, this formed no part of the appellant's grounds of appeal and was not argued before me and so I shall say no more about it.

> charges of professional misconduct were being made to add to the factual allegations on which the charges were based an allegation of dishonesty in the event that the respondent doctor had had the temerity to deny any of the factual allegations. Counsel told their Lordships that it was not the general practice and that he was not aware of a previous case where that had been done. No explanation of why it was thought right to add the allegations of dishonesty in the present case was offered. In their Lordships' opinion the addition of the allegations of dishonesty in the present case was unnecessary and oppressive. The allegations added nothing to what would have been shown to be the degree of culpability of Dr Misra if the substantive allegations that he had declined to admit were found proved against him."

A strict textual interpretation of this passage would confine the oppressive conduct to the formulation of charges based on the registrant's forensic reaction to the initial complaint in the pre-trial period. But the underpinning reasoning surely applies equally to the situation, as here, where a registrant has doughtily defended allegations against him in the fact-finding phase. It surely leads to say that it is equally oppressive for that defence by the registrant to be used against him in the impairment and sanctions phases.

65. In *Amao v Nursing and Midwifery Council* [2014] EWHC 147, the registrant was found in the fact-finding phase to have acted aggressively towards colleagues. In the impairment phase, she was then cross-examined as to whether she agreed with the panel's findings on each of the factual allegations. The legal adviser made it clear that it would not be proper to seek to get Ms Amao to admit things which she had previously denied but that she could be asked whether she accepted the panel's findings. Her refusal to do so contributed to a finding of a high risk of repetition which led to a finding of impairment to practise which in turn led to her being struck off the register. Walker J at [161] held:

> "Ms Amao was perfectly entitled to say that she did not accept the findings of the panel: she had a right of appeal which she was entitled to exercise. In all the circumstances it was thoroughly inappropriate, almost Kafkaesque, to cross-examine Ms Amao in a way which implied that she would be acting improperly if she did not "accept the findings of your regulator"."

And at [163] that

> "the panel's finding that there was a high risk of repetition was vitiated by an unfair procedure".

66. I have recently dealt with this issue in *General Medical Council v Awan* [2020] EWHC 1553 (Admin) (17 June 2020), where the GMC appealed a sanction of suspension inter alia on the ground that the MPT had not properly reflected in its sanction the way the registrant conducted his defence. It was put this way by leading counsel for the GMC:

> "The implausible, incredible and inconsistent explanations provided on oath to the Tribunal were plainly relevant to Dr Awan's insight into his misconduct and the risk of repetition and yet the Tribunal failed to refer to this matter in its determination on impairment and then to reflect this aggravating factor in its determination on sanction."

67. I rejected this ground of appeal. At [37] I held:

> " I think that it is too much to expect of an accused member of a profession who has doughtily defended an allegation on the ground that he did not do it suddenly to undergo a Damascene conversion in the impairment phase following a factual finding that he did do it. Indeed, it seems to me that to expect this of a registrant would be seriously to compromise his right of appeal against the factual finding, and add very little, if anything, to the principal allegations of culpability to be determined."

68. At [38] I held that an accused professional has the right to advance any defence he or she wishes and is entitled to a fair trial of that defence without facing the jeopardy, if the defence is disbelieved, of further charges or enhanced sanctions. And at [40] I stated that in the absence of any significant hiatus between the factual finding and the impairment/sanctions phase in which full reflection can be undergone, it is not reasonable to expect an accused professional who has defended the case on the ground that he did not do what was alleged suddenly to admit everything in the impairment phase.

69. In contrast, in *Yusuff v GMC* [2018] EWHC 13 (Admin), Yip J heard a challenge to a decision on a review which was held some time after the initial sanction was imposed. At [18] she observed that "as para 52 of the Sanctions Guidance makes clear, refusal to accept the misconduct and failure to tell the truth during the hearing will be very relevant to the initial sanction." She further observed that a want of candour and continued dishonesty may be taken into account by the Tribunal in reaching its conclusions on impairment.

70. Paragraph 52 of the Sanctions Guidance states that "a doctor is likely to lack insight if they… failed to tell the truth during the hearing (this includes being dishonest or misleading)."

71. It is hard to square these statements with Lord Scott's comments in *Misra*. In the criminal sphere there is no principle of a plea in aggravation by the prosecutor whereby he seeks an enhanced sentence because the defendant's defence was rejected as untrue. A plea of not guilty attracts no aggravation; a plea of guilty, however, attracts mitigation. In my opinion that axiom should equally apply in disciplinary proceedings. I can see, were a defence to be rejected as blatantly dishonest, then that would say something about impairment and fitness to practise in the future. But there would surely need to be a clear finding of blatant dishonesty for that to be allowed. Absent such a finding it would, in my judgment, be a clear encroachment of the right to a fair trial for the forensic stance of a registrant in the first phase to be used against him in the later phases.

72. In my judgment a distinction should be drawn between a defence of an allegation of primary concrete fact and a defence of a proposed evaluation (or exercise of discretion) deriving from primary concrete facts. The former is a binary yes/no question. The latter requires a nuanced analysis by the decision-maker with a strong subjective component. If a registrant defends an allegation of primary concrete fact by giving dishonest evidence and by deliberately seeking to mislead the MPT then that forensic conduct would certainly say something about impairment and fitness to practise in the future. But if, at the other end of the scale, the registrant does no more than put the GMC to proof then I cannot see how that stance could be held against him in the impairment and sanctions phases. Equally, if the registrant admits the primary facts but defends a proposed evaluation of those facts in the impairment phase then it would be Kafkaesque (to use Walker J's language) if his defence were used to prove that very proposed evaluation. It would amount to saying that your fitness to practise is currently impaired because you have disputed that your fitness to practise is currently impaired.

73. The rejection of the appellant's defence on the facts by the MPT in this case did not entail a finding that he was guilty of blatant dishonesty or the deliberate misleading of the tribunal. It is true that in a number of respects the appellant's case on the facts was rejected on the balance of probability but it is clear that the rejection did not involve fixing him with blatant dishonesty. Take for example allegation 4(a). That said that at the conclusion of Patient A's first operation, the appellant failed to pay attention to the concerns being raised by the anaesthetic staff whilst the baby remained on the operating table. In support of the allegation the GMC adduced evidence from the anaesthetists Dr Waring and Dr Clement. The appellant did not suggest that they were lying; rather, he sought to put a different complexion on their evidence by saying that he himself had noticed the signs but that he expected things to improve within a few hours. The rejection of that account did not involve making a judgment whether the appellant was lying or telling the truth. It merely preferred, on balance of probability, the evidence of the anaesthetists to that of the appellant.

74. It is perfectly normal in a forensic process, where there are two versions of events, for one version to be preferred by the fact-finder (on the balance of probability) but without a consequential condemnation of the exponent of the other version as a liar. This unsententious approach reflects a judicial self-awareness of our fallibility as fact-finders, as Baroness Hale of Richmond recognised in *Re B (Children) (Care Proceedings: Standard of Proof)* [2008] UKHL 35, [2009] AC 11 at [56] where she said:

> "…the "risk" is not an actual risk to the child but a risk that the judge has got it wrong. We are all fallible human beings, very capable of getting things wrong."

And to similar effect in *Re L and B (Children)* [2013] UKSC 8, [2013] 1 WLR 634 at [43] where she said:

> "…the disconcerting truth is that, as judges, we can never actually *know* what happened: we were not there when whatever happened did happen. We can only do our best on the balance of probabilities …" (original emphasis)

75. In my judgment, in the absence of findings of blatant dishonesty, the MPT should not have used against the appellant in the impairment and sanctions phases his decision to contest the allegations made against him in the Coroner's court. Nor should the MPT have used against the appellant in those phases his failure to accept those findings in circumstances where they were soon replicated by charges brought against him by the GMC before the MPT. It is in this sense that the conclusions of the Coroner were unfairly deployed against him.

76. Nor should the MPT have used against the appellant in the impairment and sanctions phases his decision fully to contest the charge before the tribunal. His deployment of a robust defence, which was his right, should not have been construed as a refusal to remediate, let alone an incapacity to remediate.

77. Therefore, I have reached the conclusion that the decision-making processes that led to the finding of impairment, as well as the decision on sanction, were unjust because of a serious procedural irregularity. I reiterate my opinion in *GMC v Awan* at [40] that the absence of any significant gap between the findings of fact and the commencement of the impairment and sanctions phases means that it is unrealistic to expect a registrant who has unsuccessfully defended the fact-finding phase then almost immediately in the impairment phase to demonstrate full remediation by fully accepting in a genuinely sincere manner everything found against him. In my opinion the capacity of the registrant to remediate sincerely should be judged by reference to evidence unconnected to his forensic stance in the fact-finding phase (unless the fact-finding decision included findings of blatant dishonesty by the registrant).

78. The next question is: would the outcome have been the same if this irregularity were not present? I can see a strong argument for saying that the result might well have been the same, but as Ms Hearnden rightly accepts the balance of probability is not enough – she must show that the decision would inevitably have been the same: *R (Smith) v North Eastern Derbyshire Primary Care Trust* [2006] 1 WLR 3315 per May LJ at [10].

79. I cannot say that the decision would inevitably have been the same. I am not going to be drawn in to making a probabilistic assessment of the likelihood of the decision being the same, beyond saying that I think it is quite likely. I cannot find that the conclusion reached by the MPT which I have set out at para 18 above would inevitably be the same when the unfair evidence is stripped out of the exercise. That conclusion said that "the gravity of the misconduct is such that erasure would remain the appropriate sanction even if there was no ongoing risk to patient safety." The misconduct of itself cannot justify the ultimate sanction. It informs, among other things, the criterion of current impairment of fitness to practise. That in turn informs in the sanctions phase the criterion of the protection of the public in all three of its aspects. It is clear from the reasoning of the MPT that the criterion of current impairment of fitness to practise was decided not only by reference to the proven misconduct but also by reference to the appellant's forensic stance. That criterion will need to be reconsidered, and I cannot say that the outcome will inevitably be the same.

80. For the avoidance of any doubt, I record my view that all the findings of fact made by the MPT are unimpeachable, and that in the fact-finding phase the MPT bent over

backwards to ensure that the appellant was treated in a procedurally fair and correct manner.

81. In this case the MPT comprised a legally qualified chairman and two medically qualified members. Their expertise in determining how the second and third objectives in section 1(1B) of the 1983 Act are to be met in this case greatly exceeds my own. I am therefore of the opinion that it would be appropriate for the MPT to re-exercise its powers on the correct basis which I have identified.

82. On Ground 6, I therefore allow the appeal in part and remit the impairment and sanctions phases to be reconsidered by the MPT without reference to, or taking into account of:

    i) the appellant's decision to contest the allegations made against him at the inquest;

    ii) the appellant's failure thereafter to admit the narrative conclusions of the Coroner;

    iii) the appellant's decision to contest the allegations made against him at the MPT, or the manner in which he contested them.

83. I am conscious that my decision will unhappily prolong the deferment of closure in this case for all concerned, most particularly for the parents of Patient A, but also for the appellant. I regret this. I hope that the MPT will be able to reconvene at the soonest opportunity to reconsider impairment and sanction. In my opinion no further written or oral evidence will be necessary; the decision can be made on the existing written material supplemented by further skeleton arguments and oral submissions from counsel.

84. The appeal has largely failed. It has succeeded only to one small extent. In the circumstances I do not think it would be appropriate for there to be an order for costs in favour of the appellant.

85. That is my judgment.
