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Case No: CO/1771/2020

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 09/03/2021

Before :

THE HON. MR JUSTICE HOLGATE

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Between :

The Queen **(on the application of Professor Ian Young)**	**Claimant**
- and –	
General Medical Council	**Defendant**

- -
- -

Robert Kellar QC (instructed by **Carson McDowell LLP)** for the **Claimant**

Peter Mant (instructed by **GMC Legal**) for the **Defendant**

Hearing date: 14/01/2021

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Approved Judgment

Mr Justice Holgate

Introduction

1. On 14 November 2018 an Assistant Registrar ("AR1") of the General Medical Council ("the GMC") decided that allegations against the Claimant, Professor Ian Young, relating to his conduct in 2004 and 2006 should not proceed any further by virtue of rule 4(5) of the General Medical Council (Fitness to Practise) Rules 2004 (SI 2004 No 2608) ("the 2004 Rules). Subsequently, another Assistant Registrar ("AR2"), acting under rule 12 of the 2004 Rules, reviewed that determination and, by letters dated 9 January and 23 March 2020, substituted a fresh decision, this time that the allegations should proceed.

2. Rule 4(5) provides:-

> "No allegation shall proceed further if, at the time it is first made or first comes to the attention of the General Council, more than five years have elapsed since the most recent events giving rise to the allegation, unless the Registrar considers that it is in the public interest for it to proceed."

It is important to emphasise at the outset that the Registrar's task is not to see whether an allegation can be made out or whether there is unfitness to practise. Rule 4 simply involves a form of triage.

3. Likewise, although it will be necessary in this judgment to refer to findings which have been made by others, as well as to the allegations against the Claimant, it is not the Court's role in these proceedings to express any conclusions about the merits of those matters. This judgment should not be treated as if it does.

4. With the permission of Lewis J (as he then was) the Claimant applies for judicial review of the decision made by AR2, contending that the power to review under rule 12 was not engaged, alternatively, that if it was, the power was exercised unlawfully. I would like to express my gratitude to counsel for their written and oral submissions and also to Mr. Roberts for his written submissions.

5. The Claimant is Professor of Medicine at the Queen's University, Belfast, where he has previously served as the Director of the Centre for Public Health. He is Deputy Medical Director and Consultant Chemical Pathologist at the Belfast Health and Social Care Trust. He is the Chief Scientific Advisor to the Department of Health (Northern Ireland).

6. Professor Young qualified from the Queen's University in 1985. Apart from the matters the subject of the decisions under challenge he has no adverse regulatory history at the GMC during a long and distinguished career.

7. On 5 February 2018 the Claimant self-referred to the GMC following publication on 31 January 2018 of the Report by Mr. Justice O'Hara on "The Inquiry into Hyponatraemia-related Deaths" ("the Report"). That Inquiry had been established in December 2004 under the chairmanship of John O'Hara QC (as he then was) to examine the events surrounding and following the deaths of a number of children in hospitals in

Northern Ireland. The allegations considered by the GMC are based upon findings in the Report.

Hyponatraemia

8. Hyponatraemia refers to a condition in which the concentration of sodium in the blood falls below safe levels. It can arise from excessive losses of sodium caused, for example, by vomiting. It can be related to the dilution of sodium levels in the blood through excess fluid. That can result from excessive intravenous infusions ("IV") or by excessive water retention, or a combination of both.

9. Several of the children had been given an IV infusion of "Solution No.18" which contains only 0.18% sodium chloride. It is a low saline or hypotonic solution, containing only 20% of the sodium chloride found in blood. That low concentration cannot replace sodium lost through vomiting or diarrhoea and, if administered excessively or too quickly, can result in dilutional hyponatraemia. This may occur, for example, if solution No.18 is given inappropriately where a patient has already suffered sodium losses or excessive water retention. For example, children may react to illness or surgical stress with a Syndrome of Anti-diuretic Hormone Secretion ("SIADH"), which inhibits urine production and causes water retention.

10. If left untreated, a significant fall in sodium concentration may induce a cerebral oedema, leading to raised intracranial pressure, swelling of the brain stem, coma, respiratory arrest and death.

11. The symptoms of hyponatraemia are often lethargy, headaches, nausea and vomiting. The severity of the symptoms reflects the rate at which the sodium level falls. A diagnosis can be made straightforwardly by testing the levels of sodium in the blood. According to paragraph 1.33 of the Report, safe IV fluid management of a child with sodium losses cannot be assured without carrying out those tests and understanding the fluid balance. Dilutional hyponatraemia should not happen in a hospital because such a patient will be the subject of active fluid therapy or management. It is a preventable hospital illness.

12. Risks of using Solution No.18 and the dangers of dilutional hyponatraemia began to be understood more clearly from the early 1990s (Report para. 1.35).

13. This judgment is arranged under the following headings: -

Overall Chronology

14. It is necessary to begin with the tragic events which took place in late 1996, although the Claimant did not become involved until much later in 2004.

15. In the evening of 21 October 1996 Claire Roberts, who was then aged only 9, was admitted to the Royal Belfast Hospital for Sick Children ("RBHSC"). She had symptoms of vomiting, lethargy and very slurred speech. The Report described her condition as "reduced consciousness" (paragraph 2.39). Claire was placed on an IV infusion of Solution No.18. Around midnight a blood test revealed a serum sodium level of 132 mmol/l (millimoles per litre), just below the normal range of 135 to 145 mmol/l.

16. During the afternoon of 22 October 1996 Claire's condition declined and she suffered a number of seizures. Her Glasgow Coma Scores and level of consciousness reduced. Diagnostic tests were not carried out. Blood tests were not repeated until 9:30pm. The results at 11:30pm revealed that her serum sodium had fallen to the "dangerously low" level of 121 mmol/l (Report 3.146).

17. At around 2.30pm on 23 October 1996 Claire suffered respiratory arrest. Just under an hour later she was transferred to the paediatric intensive care-unit. A CT scan was carried out at 5.30am revealing severe cerebral oedema. Sadly, it was clear that because of her brain injury Claire could not survive and so life support was discontinued later that day.

18. Claire's death was not referred to the Coroner at that stage. The cause of death was certified as being "cerebral oedema secondary to status epilepticus." Hyponatraemia was omitted from the certificate, despite it being "the only confirmed diagnosis at the time." On the other hand, the certificate referred to status epilepticus, despite the unconfirmed status of that diagnosis in the absence of any EEG test. By contrast, the certificate did not mention another unconfirmed diagnosis, namely viral encephalitis (Report e.g. paragraph 3.203). The Inquiry made strong criticisms of two consultants

responsible for Claire's care (Dr Steen, a consultant paediatrician and Dr Webb a consultant paediatric neurologist) for failing to refer Claire's death to the Coroner and for their contemporaneous explanations of the cause of death (Report 3.242).

19. At the time, Claire's parents, Alan and Jennifer were led to believe that her death resulted from a viral infection and encephalitis, although the autopsy report had excluded the latter (Report 3.206, 3.227 and 3.240 to 3.241). They were not told about the hyponatraemia (see also 3.242 to 3.244).

20. O'Hara J was satisfied that a "cover-up" of the cause of death was attempted by Dr Steen and to some extent by Dr Webb, but the NHS trust had not been complicit in that attempt (Report 3.242 and 3.245-3.248).

21. On 21 October 2004 Ulster TV broadcast a programme which examined the deaths of three other children from hyponatraemia. This gave rise to considerable media interest and public disquiet. In November 2004 the Minister who then had responsibility for health in Northern Ireland set up the public inquiry under the chairmanship of Mr. O'Hara QC.

22. Mr. and Mrs. Roberts saw the documentary. They had never really understood why their daughter had died. They recognised similarities between what had happened to the other children and to Claire. They immediately contacted the hospital and raised questions about the role of fluid management in Claire's deterioration (Report 3.253). The Medical Director of RBHSC asked one of the consultants responsible for Claire's treatment, Dr Steen, to review the case notes, and if there was any reason to suggest that fluid and electrolyte management had been a factor, to ask *inter alia* the Claimant to review those notes to determine whether the case should be referred to the Coroner (Report 3.254). This was the first time that the Claimant became involved in the matter. O'Hara J found that "he was eminently well qualified to advise on this issue having significant expertise in hyponatraemia" (Report 3.255).

23. On 6 December 2004 the Claimant took part in two meetings with other doctors, including Dr Steen.

24. He then took part in the meeting with Mr. and Mrs. Roberts on 7 December.

25. The next day Mr. Roberts sent a letter to RBHSC with 10 very perceptive questions, many of which raised detailed issues about fluid management. He requested that Claire's death be referred to the Coroner and to the public inquiry.

26. On 17 December 2004 RBHSC wrote to Mr. and Mrs. Roberts to say that the Claimant's review of medical care suggested "that there may have been a care management problem in relation to hyponatraemia and that this may have significantly contributed to Claire's deterioration and death."

27. On 12 January 2005 RBHSC sent a letter to Mr and Mrs Roberts responding to the 10 questions.

28. In May 2006 the Coroner held an inquest into Claire's death. Evidence was given by doctors who had been involved in the case in 1996 and also by the Claimant. The

Coroner's verdict was that the cause of death had been cerebral oedema due to meningo-encephalitis and hyponatraemia due to excess ADH production and status epilepticus.

29. In addition to the letter of self-referral sent by the Claimant a few days after the publication of the Report, Mr. Roberts submitted a complaint to the GMC on 23 March 2018.

30. Initially, AR1 identified two allegations against the Claimant. AR2 added a third related allegation. In summary, the three allegations are:-

(1) The Claimant contributed to the letter to Mr. and Mrs. Roberts dated 12 January 2005 which included "highly questionable" content;

(2) The Claimant provided misleading evidence to the Coroner's inquest in May 2006;

(3) The Claimant failed to acknowledge failings in care and/or provided misleading/dishonest information to Mr. and Mrs. Roberts at the meeting on 7 December 2004.

The allegations are based upon findings in the Report by Mr Justice O'Hara and need to be understood in that context.

31. On 14 November 2018 AR1 issued a decision letter on behalf of the GMC in which he concluded that the public interest in investigating allegations (1) and (2) was insufficient to outweigh other considerations so as to justifying "waiving" the " 5-year rule". He said that this had been " a very finely balanced decision". The Claimant was told that the GMC would not be taking any further action and its inquiry would be closed.

32. On 19 December 2018 Mr. Roberts sent a detailed letter to the GMC seeking a review of the decision by AR1.

33. On 27 March 2019 the GMC wrote to the Claimant to announce that AR2 had decided to begin a review under rule 12(2) of the decision not to proceed under rule 4(5), but only in relation to allegation (2), and not allegation (1). Both the Claimant and Mr. Roberts were invited to make further representations and did so.

34. On 7 October 2019 AR2 issued a further decision letter announcing that the review would be extended to cover allegation (1) and also a new allegation (3). The Claimant was given the opportunity to make further representations on the review, which he took up.

35. On 9 January 2020 AR2 issued a decision stating that in her opinion there had been material flaws in the decision of AR1 and that a fresh decision was necessary in the public interest. She stated that the allegations would be referred to the Case Examiners for consideration under rule 8 of the 2004 Rules.

36. On 6 February 2020 Carson McDowell LLP, the Claimant's solicitors, sent a pre-action protocol letter to the GMC. One of the grounds advanced was that in the decision dated 9 January 2020 AR2 had failed to make a fresh decision weighing the public interest factors for and against waiver of the time limit in rule 4(5) in the light of her conclusions. I think that there was some force in this complaint at the time. Reversing

a previous decision under rule 4(5) so as to allow allegations to go forward for investigation, whereas previously it had been determined that the matter was closed, would be a serious matter for any doctor. Furthermore, an additional allegation had been added. It might be said that, because AR1 had treated his decision as being "very finely balanced" and AR2 had attached substantially more weight to factors favouring "waiver", it was therefore implicit that AR2 had found that the 5-year limitation period should not apply. But this change of position was too important to be left to implication. It was a decision not to apply the 5-year limitation period which was potentially subject to judicial review. The balance had to be struck explicitly.

37. AR2 sought to do this in the further decision letter dated 16 March 2020.

The Report by Mr Justice O'Hara

38. Because the allegations against the Claimant are based upon the Report, and because of the nature of the Claimant's challenge, it is necessary to summarise relevant passages in that document in order to understand reasoning in the decisions of AR1 and AR2. Several of the issues were interrelated and certain parts of the Report should be understood in the light of conclusions drawn elsewhere, whether in earlier or subsequent paragraphs. It is essential to read the relevant parts of the Report as a whole.

39. Dr Sands, a paediatric registrar, came on duty in Claire's ward at 9am on 22 October 1996 (paragraph 3.51). He was aware of the results of the blood test carried out the previous evening and accepted that he should have repeated the blood tests that morning. He was only one of a number of clinicians who had the opportunity to repeat electrolyte tests. The failure to do so was both individual and collective (3.68). Dr Sands ordered hourly neurological observations. But blood tests were not repeated and neither a CT scan nor an EEG was carried out (3.71). Dr Sands was concerned about Claire's level of consciousness. He described her as "very unwell" (3.72).

40. Dr Sands contacted the consultant Dr Webb. The latter was told about the sodium reading of 132 mmol/l, but he believed that that was a result from the morning of 22 October 1996, rather than the previous evening (3.76). The Report criticised the failures to carry out a CT scan, an EEG test and electrolyte management during the course of that day (3.80 and 3.93).

41. Dr Webb acknowledged his error in thinking that the serum sodium result was from a test carried out in the morning of 22 October, and admitted that if he had understood the result was from the previous evening, he "would have requested an urgent repeat sample" because Claire was receiving the No.18 solution and he could not have been confident that the sodium level was irrelevant to her presentation (3.88). The Report found that his confusion about the timing of the blood tests was a matter of significance and concern. The records contained no timings for the test results. The very fact that they were the only results for a patient admitted the previous day should have caused him to double-check the timings (3.89).

42. Doctors who saw Claire on 22 October 1996 should have been aware of her declining consciousness and her "vital signs and changed neurological status" from the charts. These factors should have been treated as "warning signals" (3.98 to 3.100).

43. Notwithstanding the fact that Claire's sodium levels had not been checked since the previous night, Dr Webb still did not direct repeat blood tests when he saw her at 5pm. Dr Sands arrived at 5:15pm. He said to the Inquiry that he had "been under the impression that a full blood test had been performed and that the results were awaited". O'Hara J said "I cannot understand the basis for any such expectation from the entries in the record" (3.114). Responsibility for the failure to take a number of steps at around 5.15pm (including the carrying out of blood tests and an EEG, reconsideration of diagnosis and obtaining advice on admission to intensive care), lay overwhelmingly with Dr Webb and Dr Sands (3.115).

44. The Inquiry's main concern about the meeting with Mr. and Mrs. Roberts on 7 December 2004 was that "there was no acknowledgement of any of the very many failings in care." "There was no acknowledgment at the meeting that Claire should have had a repeat blood test on the morning of 23rd October [that must have been intended to read 22nd October] even though Professor Young was already of the opinion that the "monitoring of serum electrolytes did not occur with sufficient frequency given the severity of Claire's clinical condition" (3.260). I note that that quotation is taken from a witness statement given by the Claimant to the Inquiry, addressing a question about the views he had formed on shortcomings or deficiencies in the care given to Claire when he reviewed her case notes in late 2004. It echoes points noted by the Inquiry in earlier parts of its Report (see [39] to [43] above). The Chairman said that there were more examples "but they all illustrate a lack of openness, especially on the part of Dr Steen" (3.260).

45. Paragraph 3.261 of the Report then stated:-

> "That this was a very serious breach of duty and good faith becomes even more obvious when one considers that at that point Claire's death was about to be referred to the Coroner and Mr. and Mrs. Roberts had already indicated that they wished it referred to this Inquiry (which had been started some weeks before)."

The above findings are relevant to allegation (3), but also, as we shall see, to allegation (1).

46. The Inquiry noted that the letter from Mr. and Mrs. Roberts dated 8 December 2004 "raised detailed questions about fluid management, which showed how alert they were to this aspect of care" and that when Professor Young saw the list of 10 questions, he was amazed by how much Claire's parents had taken in at the meeting (3.262).

47. The Inquiry found that the letter from RBHSC dated 12 January 2005 replying to Mr. and Mrs. Roberts must largely have been the work of Dr Steen with contributions from the Claimant. Some of the content was found to be "highly questionable" referring to four matters (3.264). Mr Kellar QC for the Claimant pointed out that they did not specifically refer to testing of sodium levels or fluid management. However, item (iv) was fairly broad, stating that the response had ignored other matters completely, before going on to give one example. Reading the Report fairly and as a whole it would be wholly unrealistic to think that its author did not also have in mind the criticism he had just made of the Claimant in paragraphs 3.260 and 3.261 (see [44] and [45] above). There was no need for him to spell that out again. In his letter of 8 December 2004 Mr.

Roberts had specifically asked how many blood tests had been carried out on 22 October 1996 and why the sodium level had not been rechecked until the blood test carried out at 9.30pm that day. The reply on 12 January 2005 had maintained that in 1996 the "normal procedure" would have been to monitor sodium levels every 24 hours. It was not suggested that the letter told Mr. and Mrs. Roberts anything about the point referred to in paragraph 3.260 of the Report (see [44] above).

48. O'Hara J found that the letter dated 12 January 2005 was "inaccurate, evasive and unreliable" and, to make matters worse, was sent to the Coroner as well as to Claire's parents. The Coroner must have assumed that it represented the NHS Trust's considered assessment of the issues he was to investigate (3.265). Having said that, the Chairman made it clear that his criticism about what Mr. and Mrs. Roberts were or were not told was largely directed at Dr Steen (3.266).

49. In relation to the inquest (the subject of allegation (2)), it is necessary to quote paragraphs 3.274 to 3.280 in full:-

> "3.274 Unfortunately, there is no formal transcript of the oral evidence given at inquest. However, such notes and minutes as do exist, strongly suggest that neither Professor Young, nor Drs Webb, Sands or Steen explained to the Coroner that Claire's hyponatraemia was related to fluid or electrolyte mismanagement.
>
> 3.275 The failure to repeat the initial blood test was an issue of mismanagement, which had to be addressed by the Trust. This was apparent during preparation for inquest. When the Litigation Management office sent witness statements to Professor Young (on 7th April 2006) for comment, he drew attention to what he termed "*substantial issues*" in Dr Webb's statement – namely his recognition that there had been a failure to take a routine electrolyte sample on the morning after admission and that it was indeed the hyponatraemia which had led to the cerebral oedema. Professor Young indicated that these issues "*could certainly become significant at the inquest*".
>
> 3.276 In this connection, Dr Webb had specifically conceded in his statement to the Coroner that he had misunderstood the Monday night blood test as being a blood test from the Tuesday morning and that had he not so misunderstood it, he would have directed an urgent repeat blood test at about 14:00 on Tuesday. Professor Young agreed that this is indeed what should have been done and even Drs Steen and Sands were both to agree that the blood test should have been repeated long before Tuesday night.
>
> 3.277 However, I find little evidence that Professor Young brought this matter to the attention of the Coroner. Instead and having agreed that Claire had the potential for electrolyte imbalance, he advised the Coroner that "*a blood sample every 24 hours would be good clinical practice*".

> 3.278 I consider that it was misleading to suggest to the Coroner that a blood sample once a day in such circumstances would have been good clinical practice. Notwithstanding the practice in other cases, it was not good clinical practice in the case of a child on low sodium intravenous fluids, with a neurological history, a low level of consciousness, a low sodium reading, an unknown fluid balance, and in circumstances where she was not responding to treatment.
>
> 3.279 Although Professor Young understood that his role was "*to assist on the key issues being drawn out at the Inquest*", there appear nonetheless to be other examples where Professor Young failed to draw key issues to the attention of the Coroner. While the Medical Director, Dr McBride, informed Mr and Mrs Roberts that Professor Young's "*review has suggested that there may have been a care management problem in relation to hyponatraemia and that this may have significantly contributed to Claire's deterioration and death*" Professor Young flatly denied contributing to this particular assertion and advised the Coroner that the death was not one which necessarily would have had to have been reported to the Coroner in 1996 because of a lack of awareness of hyponatraemia at that time. He told the inquest that he did not believe that there were lessons to be learned from Claire's case and gave further reassurance that Claire's fluid management was in keeping with the recommendations of 1996.
>
> 3.280 In the light of this evidence, I am of the view that Professor Young shifted from his initial independent role advising Dr McBride to one of protecting the hospital and its doctors." (original emphasis)

50. It is also relevant to note the thinking of O'Hara J underlying his recommendations in chapter 9 of the Report. One of his guiding principles was that "leadership and candour must be accorded the utmost priority" (9.1).

Legal Framework

51. The GMC is established by s.1 of the Medical Act 1983 ("the 1983 Act"). Its "overarching objective" is "the protection of the public" (s.1(1)). Section 1(1B) provides:-

> "The pursuit by the General Council of their over-arching objective 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 profession."

52. The Registrar of the GMC is responsible for keeping the register of medical practitioners (s.2). Section 35CC(1) enables rules to be made under paragraph 1 of schedule 4 for the Registrar to exercise the functions of the "Investigation Committee" under s.35C.

53. Section 35C applies where an allegation is made to the GMC that a medical practitioner's fitness to practise is impaired. Impairment is defined in s.35C(2) to include "misconduct". The Investigation Committee decides whether an allegation ought to be considered by a Medical Practitioners Tribunal and if not, whether a "warning" should be given (s.35C (4) to (7)).

54. Rule 4(1) of the 2004 Rules provides that an allegation shall initially be considered by the Registrar. In practice this function is delegated in each case to one of a number of Assistant Registrars. Where the Registrar considers that an allegation falls within s.35C(2) of the 1983 Act he must refer it to a medical and a lay Case Examiner for consideration under rule 8 (rule 4(2)). Where the Registrar decides that the allegation does not fall within s.35C(2) he must notify the maker of the allegation (rule 4(2A)). Where a matter is referred for consideration under rule 8 the Registrar must notify the practitioner of the allegation, giving him an opportunity to respond. He may also carry out investigations (rule 7).

55. Under rule 8 the Case Examiners may *inter alia* determine that the allegation should not proceed further, or may issue a warning to the practitioner under rule 11(2), or may refer the matter to a Medical Practitioners Tribunal.

56. Section 35CC(5) states:-

> "Rules under paragraph 1 of Schedule 4 may make provision for section 35C(4) to (8) not to apply in relation to an allegation if-
>
> (a) at the time when the allegation is made, more than five years have elapsed since the most recent events giving rise to the allegation, and
>
> (b) the Investigation Committee consider that it would not be in the public interest to investigate the allegation."

That is the underpinning in the primary legislation for rule 4(5).

57. Section 35CC provides for the disapplication of the power to pursue "impairment" allegations where *both* the 5-year period has elapsed *and* it would *not be in the public interest* to investigate an allegation. The primary legislation is not expressed so as to confer immunity from investigation of an allegation simply because the 5-year period has elapsed. However, rule 4(5) has been worded differently so that the GMC is not to proceed with an allegation more than 5 years old *unless* it is in the public interest to do so. The legal justification for this is unclear. The problem may stem from the fact that until s. 35CC(5) came into effect in August 2015 there was no specific provision in the primary legislation addressing this subject, although a version of rule 4(5) had existed

since the 2004 Rules were enacted (see the consultation paper on the fitness to practise code issued by the Department of Health in August 2014). Perhaps the current version of rule 4(5) was not intended to depart from the primary legislation as a matter of substance.

58. This issue does not appear to have been raised in any previous judicial review. That is not surprising. It is not a point which a medical practitioner would be likely to raise. Quite possibly the court has been referred to rule 4(5) but not s. 35CC(5). Fortunately, the outcome of the grounds of challenge in this case are not affected by this point and the court has not had the benefit of detailed submissions on it. But it is not something which can be ignored. It should be considered by the GMC and the Professional Standards Authority. Rule 4(5) is delegated legislation which should accord with the rule-making power in the primary legislation, s. 35CC(5). One solution *might* be to read rule 4(5) so that it is compatible with the terms of that power. In other words, the Committee, or the Registrar, should proceed with an allegation that is more than 5 years old and falls within the fitness to practise regime, unless satisfied that it would *not* be in the public interest to do so.

59. A practice has developed of asking whether the 5-year rule should or should not be "waived", or whether a particular factor tells for or against "waiver" of that rule. Those terms are inconsistent with both s.35CC(5) and rule 4(5). Instead, the relevant question is whether it is in the public interest for the 5-year restriction to be applied. In the different context of private civil law claims, it is appropriate to speak of a limitation period being "waived. This is because a party generally has an entitlement to rely upon limitation as a defence but may elect whether or not to do so (see e.g. McGee: Limitation Periods (8th edition) at 21.019 *et seq*). Accordingly, a party may become estopped from relying upon a limitation period. The 5-year restriction in rule 4(5) is different. It only provides protection for medical practitioners against allegations being pursued after the 5-year period has elapsed if the Registrar is satisfied that it would not be in the public interest for the allegation to be investigated. Unlike a limitation period in private law litigation, rule 4(5) does not give a medical practitioner an absolute right to rely upon the 5-year rule. However, it is impossible to avoid using the term "waiver" in this judgment when dealing with the reasoning of AR1 and AR2 and certain grounds of challenge.

60. Consideration of the "public interest" may involve the weighing of factors which may pull in different directions, some in favour of investigating an allegation and others not, taking into account *inter alia* the reasons for, and the effects of, the lapse of time. But the statutory question remains whether, after taking into account the relevant considerations in any individual case, the overall view of the public interest is that the allegation should or should not be investigated.

61. The role of the Assistant Registrar under rule 4 is referred to within the GMC as "triage" (see *R (Rita Pal) v General Medical Council* [2009] EWHC 1061 (Admin) at [32]). Collins J went on to hold at [33]:-

> "It is no part of the Registrar's functions to decide whether there has been unfitness to practise. Equally, it is not part of his functions generally to make investigations to see whether the facts of the complaint can be established or not. The Registrar will normally look only at the allegations that are made and

> decide whether, if they are established, they are capable of supporting a finding of professional misconduct, or misconduct in the context of the test that has to be applied."

The judge also explained the limited ambit of the power to carry out investigations under rule 4(4) at [35]:-

> "Since the general approach, which is implicit, and perhaps even explicit, in the procedure is that the Registrar will look at the allegation made, rather than go into any question as to whether the facts are likely to be established or not, it is difficult to see that there can be an perversity, generally speaking, in failing to make any particular inquiries which go to that issue. Of course, it is desirable, sometimes essential, that inquiries should be made in order to see precisely what actually is being alleged, because frequently allegations made are not at all clear. It may well be that in a given case it is not entirely apparent whether or not there is any foundation for the suggestion that misconduct might be established and it is necessary to find out a little more precisely what the allegation amounts to. It would be wrong, in my judgment, for a Registrar simple to say, "This is a somewhat obscure allegation. Although I recognise that it might be possible to identify what actually was at the heart of it by making some inquiries, I am not obliged to do so, and I throw it out for that reason". That, although it is a matter going the other way from the circumstances of this case, I think, on the whole, would be a wrong approach. Equally, if the allegation depended upon a particular matter, and it was relatively straightforward to find out from an independent source whether that was indeed the true position, because the allegation may state something which can easily be verified one way or the other, then again it may well be that it would be wrong for the Registrar to fail to make the necessary simple inquiry which would sort the matter out one way or another. Those are but examples. One has to look at the circumstances of each individual case to see whether the Registrar did or did not unlawfully fail to make particular inquiries. "

62. It is well-established that the only person empowered to apply the 5-year rule is the Registrar, or an Assistant Registrar acting on his behalf *(R (Peacock) v General Medical Council* [2007] EWHC 585 (Admin) and *R (Lee) v General Medical Council* [2016] 4 WLR 34 at [46] to [48]). There is no later stage at which the rule may be applied. However, the Registrar may revoke and correct a decision to pursue allegations further under rule 4(5) on the grounds of a fundamental mistake as to fact (*R (Chaudhuri v General Medical Council* [2013] EWHC 6621 (Admin)).

63. Mr Kellar QC referred the court to two authorities stating that it was inappropriate to either water down or reword the test in rule 4(5) which, as originally enacted, required the Registrar to be satisfied that there were "exceptional circumstances" for proceeding with the case in the public interest (*R (Gwynn) v General Medical Council* [2007] EWHC 3145 (Admin) at [43] and *D v General Medical Council* [2013] EWHC 2839

(Admin) at [22]). However, in December 2015 the "exceptional circumstances" test was revoked. It is now necessary to apply the wording of the amended rule 4(5), in the context of s.35CC(5), without any additional gloss.

64. Even so, rule 4(5) as amended still provides an important protection for medical practitioners in respect of allegations more than 5 years old, subject to the public interest test.

65. Both parties agreed that the "Guidance for decision makers on Rule 4(5)" should be treated as containing "obviously material considerations" (see *In Re Findlay* [1985] AC 318 333-4 *and R (Friends of the Earth Limited) v Heathrow Airport Limited* [2020] UKSC 52 at [110] to [120]). But this case has not raised any issues about the *interpretation* of the Guidance, which may be an objective question of law for the court. Instead, the court has been referred to passages in the Guidance the *application* of which involves the use of judgment by an Assistant Registrar. In proceedings for judicial review that is a matter for the decision-maker (see by analogy *Tesco Stores Limited v Secretary of State for the Environment* [2012] PTSR 983 at [19]; *Hopkins Homes Limited v Secretary of State for Communities and Local Government* [2017] 1 WLR 1865 at [26]; *East Staffordshire Borough Council v Secretary of State for Communities and Local Government* [2018] PTSR 88 at [9]). As Mr Mant submitted on behalf of the GMC, where the Claimant's criticisms involve a challenge to the exercise of judgment by AR2, the Court may only intervene on *Wednesbury* principles.

66. Paragraph 35 *et seq.* of the Guidance deals with the assessment of the "public interest". Paragraph 42 states:-

> "As a starting point, the Registrar should take into account the following matters:
>
> i. The length of the relevant period (beyond five years)
>
> ii. The reason(s) for the lapse in time
>
> iii. The extent to which relevant evidence is no longer available due to the lapse of time
>
> iv. The gravity of the allegation
>
> v. The number of incidents alleged (as distinct from the gravity of the allegation itself):is there a pattern of misconduct or a single episode
>
> vi. The extent of any continuing unwarranted risk to the public and/or to public confidence in the medical profession
>
> vii. The extent to which the allegation has been ventilated before other public/adjudicatory bodies such as the police, the coroner, the criminal or civil courts, other regulatory bodies and the practitioner's employer and the outcome of that ventilation"

Paragraph 41 advises that that list is not exhaustive and what factors are material in any particular case depends upon the circumstances.

67. Rule 12 of the 2004 Rules provides as follows:

> "**12.— Review of decisions**
>
> (1) Subject to paragraph (2), the following decisions may be reviewed by the Registrar–
>
> (a) a decision not to refer an allegation to a medical and a lay Case Examiner or, for any other reason, that an allegation should not proceed beyond rule 4;
>
> (b) a decision not to refer an allegation to the Committee or to the MPTS for them to arrange for it to be considered by a Medical Practitioners Tribunal;
>
> (c) a decision to issue a warning in accordance with rule 11(2), (4) or (6); or
>
> (d) a decision to cease consideration of an allegation upon receipt of undertakings from the practitioner in accordance with rule 10(4).
>
> (2) The Registrar may review all or part of a decision specified in paragraph (1) on his own initiative or on the application of the practitioner, the maker of the allegation (if any) or any other person who, in the opinion of the Registrar, has an interest in the decision when the Registrar has reason to believe that—
>
> (a) the decision may be materially flawed (for any reason) wholly or partly; or
>
> (b) there is new information which may have led, wholly or partly, to a different decision,
>
> but only if one or more of the grounds specified in paragraph (3) are also satisfied.
>
> (3) Those grounds are that, in the opinion of the Registrar, a review is–
>
> (a) necessary for the protection of the public;
>
> (b) necessary for the prevention of injustice to the practitioner; or
>
> (c) otherwise necessary in the public interest.
>
> (4) The Registrar shall not, save in exceptional circumstances, commence a review of all or part of a decision specified in paragraph (1) more than two years after it was made.

(5) Where the Registrar decides to review all or part of a decision specified in paragraph (1), he shall in writing—

(a) notify the practitioner, the maker of the allegation (if any) and any other person who, in the opinion of the Registrar, has an interest in the decision of the decision to review and give reasons for that decision;

(b) notify the practitioner, the maker of the allegation (if any) and any other person who, in the opinion of the Registrar, has an interest in the decision of any new information and, where appropriate, provide them with that information; and

(c) seek representations from the practitioner, the maker of the allegation (if any) and any other person who, in the opinion of the Registrar, has an interest in the decision regarding the review of the decision,

and shall carry out any investigations which, in the opinion of the Registrar, are appropriate to facilitate the making of the decision under paragraph (6).

(6) Where the Registrar, taking account of all relevant material including that obtained under paragraph (5), concludes that all or part of a decision specified in paragraph (1) was materially flawed (for any reason) or that there is new information which would probably have led, wholly or partly, to a different decision and that a fresh decision is necessary on one or more of the grounds specified in paragraph (3), he may decide—

(a) to substitute for all or part of the original decision any decision which he could have made under Part 2 of these Rules; or

(b) that an allegation should be referred for reconsideration by the Case Examiners under rule 8, 10 or 11.

Otherwise, he must decide that the original decision should stand.

(7) Where the Registrar has reviewed all or part of a decision specified in paragraph (1), he shall notify–

(a) the practitioner;

(b) the maker of the allegation (if any); and

(c) any other person who, in the opinion of the Registrar, has an interest in receiving the notification,

in writing, as soon as reasonably practicable, of the decision under paragraph (6) and the reasons for that decision."

68. A decision to apply the time limit in rule 4(5), so that an allegation is not pursued, falls within the power to review decisions under rule 12 (see rule 12(1)(a)). In the present case, the first issue was whether the decision of AR1 dated 14 November 2018 was "materially flawed" given that there was no "new information" (see rule 12(2)). But the power to review would not arise unless one or more of the grounds in rule 12(3) was also satisfied. Here, it was not said that a review was necessary for the protection of the public and so it was necessary for AR2 to be satisfied that it was "otherwise necessary in the public interest." Rule 12(5) requires the medical practitioner and the maker of an allegation to be notified of the decision to review and given an opportunity to make representations. There is no dispute in this challenge about those requirements having been satisfied. AR2 concluded that there were material flaws in the decision of AR1 and that a fresh decision was necessary in the public interest (rule 12(6)). She decided that a fresh decision on the application of rule 4(5) should be substituted for that previously taken by AR1, rather than allowing the original decision to stand (rule 12(6)). She concluded that the three allegations should be referred to the Case Examiners for consideration under rule 8.

69. Although one purpose of the 2004 Rules is to provide "proper protection" for a medical practitioner against whom accusations are made, it is also necessary to have regard to the over-arching objective of the GMC set out in s.1(1A) of the 1983 Act, which includes not only the protection of the health, safety and well-being of the public, but also the promotion and maintenance of public confidence in the medical profession and proper professional standards and conduct. Thus, the public interest, as so defined, is the primary purpose guiding the interpretation of the 2004 Rules (see *Zia v General Medical Council* [2012] 1 WLR 504 at [35] and [46] and Farbey J in *R (Rudling) v General Medical Council* [2019] PTSR 843 at [43]).

70. This is an application for judicial review, not an appeal under s.40 or s.40A of the 1983 Act. Plainly the Court is reviewing the judgments reached by AR2. It is not determining the issues before AR2 for itself and may not substitute its own view. It may only intervene if AR2 has acted in excess of jurisdiction or committed a public law error. As in other areas of public law, the court should discourage "excessive legalism" in the criticisms made of decisions by Assistant Registrars. Their decisions should be read fairly and as a whole.

71. Mr Mant sought to persuade the court to go further. He relied upon the principle in *Raschid v General Medical Council* [2007] 1 WLR 1460 at [19] that in an appeal under s. 40 the court will accord "special respect" to the judgment of a Medical Practitioners Tribunal on sanction, given that a principal purpose of that jurisdiction is the preservation and maintenance of public confidence in the profession. The same may apply to findings by a Tribunal on whether proven failings amount to misconduct or impairment of fitness to practise (*Ghosh v General Medical Council* [2001] 1 WLR 1915 at [34]). But the court will not defer to a Tribunal any more than is warranted by the circumstances. There are some issues, for example dishonesty, where the court can assess what is necessary to maintain public confidence in the profession for itself (see e.g. *General Medical Council v Jagjivan* [2017] 1WLR 4438 at [40] and *General Medical Council v Zafar* [2020] 4 WLR 82 at [52]).

72. In this case I do not consider that deference is owed to AR2's decision, for a combination of reasons. First, the 5-year rule provides a potentially important protection for medical practitioners at the outset before a matter is referred for

consideration by Case Examiners or by a Tribunal. Second, the effect of AR1's decision was that GMC's consideration of the allegations against the Claimant came to an end. That appeared to bring finality to the matter, although the decision was liable to be reviewed under rule 12. Third, this is a case where the Assistant Registrars have reached opposite conclusions on the application of rule 4(5) and so the criticisms made on behalf of the Claimant of AR2's decision need to be carefully considered by the court. Fourth, the allegations are based upon findings previously reached in the Report by O'Hara J and the public interest considerations are not dependent upon the expertise of the profession.

A summary of the decisions by the Assistant Registrars

AR1's decision

73. In his decision dated 14 November 2018 AR1 summarised certain findings from the Report and assessed the length of the lapse of time. He then directed himself by reference to GMC's Guidance on public interest factors.

74. AR1 considered that the large lapse of time between 11 and 13 years pointed against waiving the 5-year rule. As for the reasons for the delay, the allegations only came to light as a result of the Inquiry. There were reasons why the Inquiry's Report could not be issued until 2018. Although it might appear that there had been an opportunity to raise concerns with the GMC, either after RBHSC responded to the ten questions or following the inquest, the Inquiry had been concerned about a lack of candour, suggesting that the issues could not have come to the GMC's attention before they had been independently scrutinised. "On balance, given the significant lapse of time, I consider the reasons for the delay point slightly against waiver of rule 4(5)."

75. AR1 then considered the extent to which evidence is no longer available due to the lapse of time. He recognised that the Inquiry had collected a large amount of information but said that there might be difficulties in obtaining further material. In relation to allegation (1), AR1 accepted that because the Claimant's *defence* was that he had focused on those parts of the letter dated 12 January 2005 *relating to his own area of expertise*, the GMC would need to obtain copies of drafts of the letter. AR1 concluded that, on balance, the non-availability of evidence in relation to allegation (1) did not weigh against waiver of the 5-year rule. As part of his reasoning AR1 set out what he understood to be the criticism in the Inquiry's Report upon which allegation (1) was based as follows:-

> "I note that the Inquiry is mainly critical that, notwithstanding that Professor Young focussed on the areas to which he had specialist knowledge, he did not review the other areas of the letter contributed to by Dr Steen for accuracy."

That was consistent with AR1's summary of the Claimant's defence to allegation (1). It would also have formed the basis for AR1's assessment of the gravity of that allegation a little further on in his decision. There is nothing in the decision letter to suggest otherwise.

76. On allegation (2), AR1 considered that the lack of a transcript of the inquest would significantly prejudice the Claimant's ability to respond, and therefore prevent him

from having "a fair and just inquiry." Consequently, this factor weighed "fairly heavily" against waiver of rule 4(5). But, of course, that finding applied solely to allegation (2).

77. AR1 then turned to deal with the gravity of the allegations. Allegation (1) involved attempting to mislead and/or contributing to the misleading of Mr. and Mrs. Roberts. This was a serious allegation "at the higher spectrum of those cases that come before the GMC". The Assistant Registrar then referred to what he considered to be mitigating factors, namely the Claimant was not the main author of the 12 January 2005 letter and there was uncertainty about which parts he had contributed and, therefore, the extent to which the Inquiry's concerns related to those parts.

78. Allegation (2) involved attempting to mislead the Coroner. This was a serious allegation "at the higher spectrum of those cases that come before the GMC". However, AR1 referred again to the absence of a transcript of the inquest. After taking into account this evidential "mitigating" factor, AR1 considered "on balance" that the gravity of the two allegations weighed in favour of waiving rule 4(5).

79. The number of incidents involved was considered to be a neutral factor.

80. AR1 then considered "the extent of any continuing unwarranted risk to the public and/or the public interest". He referred to the absence of any concerns relating to patient safety, knowledge or skills, the Claimant's professional achievements, his standing and the absence of any fitness to practise history. He then said: -

> "In my opinion, the risk to the public is therefore low. While I note there may be some public interest in investigating these concerns for protection of the public confidence given the nature of these allegations, on balance I do not consider this is significant enough to weigh in favour of waiving the five year rule."

81. It is important to note that, "on balance", AR1 did not consider that the "public interest in investigating these concerns for protection of the public confidence" was sufficiently significant to weigh in favour of waiving the 5-year rule. First, it appears that that was simply because of the countervailing weight AR1 gave to his assessment of patient safety, professional competence and the absence of any fitness to practise history. Second, in relation to this crucial factor, AR1 did not articulate what those concerns were. In particular, there was no evaluation of the criticism by the Inquiry about lack of candour and the particular circumstances in which that was said to have occurred.

82. AR1 then considered the extent to which the allegations had been ventilated before other public bodies and the outcome. He noted that they had been considered in detail by the Inquiry but recognised that the GMC, unlike the Inquiry, would focus on whether fitness to practise is impaired. However, because of the passage of time between the events relating to allegations (1) and (2) and the publication of the Inquiry's Report, AR1 considered that this factor weighed against waiver of the 5-year time limit.

83. AR1's overall conclusions were set out as follows:-

> "In my view, important factors here include the low continuing risk to public safety and the issues concerning the availability of

> evidence meaning it may not be possible for the doctor to have a just and fair inquiry into the allegations. While the allegations are serious, I am not convinced that the specific concerns highlighted are so grave that the public interest requires the allegation to proceed, *solely based on the factor of gravity alone*. This needs to be strongly weighed against the other issues raised.
>
> This is a very finely balanced decision, however on careful consideration, the factors weighing against waiver of the five year rule are significant and therefore Rule 4(5) should not be waived." (emphasis added)

84. It is to be noted that although AR1 considered the only factor in favour of waiving the 5-year time limit was the gravity of the allegations, with concern over the "public interest" being neutralised by absence of concern for patient safety, competence and fitness to practise history, he still thought that his decision was "very finely balanced". It therefore follows that whether his decision could be considered to be "materially flawed" was heavily dependent on his understanding of the nature of allegations (1) and (2) and their gravity along with his assessment of the public interest.

AR2's decisions

85. The Assistant Registrar explained how she had understood the term "materially flawed" in Rule 12 of the 2004 Rules. That was not the subject of any challenge. The criticisms by Mr Kellar QC related to the way in which AR2 applied that understanding.

86. The first "material flaw" identified by AR2 related to AR1's assessment of the gravity of the allegations. With regard to allegation (1) she found that "critical factors" had been omitted by AR1. The Claimant would have contributed to those parts of the letter dated 12 January 2005 on which he had specialist expertise, fluid management. At the time of the meeting on 7 December 2004 (and therefore before the letter was sent) the Claimant was already of the opinion that monitoring of serum electrolytes in Claire's case had not occurred with sufficient frequency, given the severity of her clinical condition. Any potential fitness to practise allegation arising from the letter had to be considered in the context of the Report as a whole. The Report had been highly critical of (a) a failure to acknowledge at the meeting on 7 December 2004 that there should have been a repeat blood test given the Claimant's state of knowledge at the time and (b) the Claimant's reference to the *normal* practice of 24-hour checks without acknowledging that observations should have been more frequent in Claire's case. These findings were also relevant to the Claimant's involvement in the letter dated 12 January 2005. First, AR1 had wrongly thought that the Inquiry's main criticism of the Claimant in this respect had been his failure to review the accuracy of sections contributed by Dr Steen falling *outside* his specialist expertise. Second, AR1 failed to address the Inquiry's criticisms of the letter which did fall *within* his expertise, including significant omissions from the letter. It therefore followed that AR1's decision was materially flawed.

87. AR2 considered that much of the same reasoning applied to allegation (3), relating to the meeting on 7 December, which AR1 had not taken into account.

88. The second "material flaw" arose from the way in which AR1 treated the reasons for the delay in raising allegation (2) with the GMC. AR2 substantially agreed with AR1 as to what those reasons were. It was completely understandable that Mr. and Mrs. Roberts had not felt able to articulate their complaints until the Inquiry had reported upon the issues with the benefit of assessment by experts. It would also have been premature for the GMC to review those matters without understanding the Inquiry's final position on the seriousness of those allegations. Like AR1, AR2 treated the Inquiry's concerns about failure to comply with the duty of candour as explaining why matters could not be raised with the GMC until the Inquiry had reported. The difference between AR1 and AR2 related to the way in which those reasons were taken into account under rule 4(5). AR2 considered that it had been illogical for AR1 to have treated the reasons for delay as weighing *against* waiver of the 5-year rule. It had to be a factor pointing in favour of waiver. That was a "material flaw".

89. The second aspect relating to allegation (2) concerned the extent of the evidence available, in particular the lack of a transcript. Although in her letter dated 7 October 2019 AR2 had thought that there might have been a material flaw in AR1's approach to this issue, in her final decision she concluded that this was not the case. However, she went on to add:-

> "I do not consider that the prejudice is such that a fair hearing of an allegation concerning Professor Young's conduct in respect of the inquest would necessarily be impossible."

90. The third "material flaw" found by AR2 related to AR1's assessment of "public interest". She stated:-

> "It remains my view that the bare statement, 'while I note that there may be some public interest in investigating these concerns for protection of the public confidence given the nature of the allegations' does not demonstrate sufficiently that the Rule 4(5) AR has considered what the public interest factors may be or why they are not significant enough to weigh against the Five Year Rule. In a case of such significant public interest and attention, the failure to note and show evidence of those considerations leaves this aspect of the decision unsafe and potentially unjustified.
>
> Even if I am wrong about this being a 'flaw', I would still have found that the Rule 4(5) AR's decision was materially flawed on other grounds for the reasons set out above. The fact that the Rule 4(5) AR failed to consider material concerns (in relation to allegations 1 and 3) plainly impacts on the overall gravity of the case against Professor Young and necessarily requires reconsideration of public confidence issues in any event."

91. The final section of AR2's letter dated 9 January 2020 considered whether a fresh decision was necessary in the public interest (rule 12(3) of the 2004 Rules). Towards the end she stated:-

> "I have carefully considered these points, in particular Professor Young's overall record as a practitioner and his ability to address these allegations so long after the events alleged. Counter to this, the allegations themselves are serious and are placed in the context of a wider context of alleged 'cover ups' at a very senior level. It is difficult to imagine a graver allegation about a doctor's probity than knowingly playing a part in a cover up of the magnitude alleged. It remains my view that the Rule 4(5) AR, who made the decision that the matters alleged were not exceptional, did not take into account important relevant factors and as such, the Case Examiners were prevented from assessing the weight of the evidence about any part that Professor Young was alleged to have played. It is in my view contrary to the public's interest and the public's expectation that a doctor's fitness to practise, in this scenario, would escape investigation because of a passage of time that could not be helped. Despite Professor Young's positive record as a practitioner, this does not in the case of an allegation such as this preclude a finding of current impaired fitness to practise and it would be for Case Examiners to assess whether or not any allegations, even if found proved, could be and have been remediated."

92. The Inquiry's Report had only used the term "cover up" in relation to allegations against Dr Steen and Dr Webb regarding their conduct in 1996/7. But it is plain that O'Hara J expressed concerns about a lack of candour on the part of others, including the Claimant, in circumstances where compliance with a duty of candour was of particular importance: namely, the provision of a sufficient, frank and accurate explanation to Mr. and Mrs. Roberts as to why their daughter had died and likewise to the Coroner.

93. In her final decision letter dated 23 March 2020 AR2 brought together the reasoning in her earlier letters and clarified a few points. She made it plain that in her judgment both the gravity of the allegations and the public interest related to breaches of the duty of candour in the circumstances of this case. Her letter confirmed that a fresh decision on the application of rule 4(5) was necessary in substitution for that taken on 14 November 2018 and that it was necessary to refer allegations (1), (2) and (3) to the Case Examiners for consideration under rule 8.

A summary of the grounds of challenge

94. There are the three grounds of challenge:-

Ground 1: AR2's decision was unreasonable and there was no "material flaw" in AR1's rule 4(5) decision;

Ground 2: AR2 erred in her approach to whether a review was in the "public interest";

Ground 3: AR2 erred in reconsidering the relevant public interest factors when reaching her own decision under rule 4(5).

Grounds 1 and 2 go to the question of whether the power to review arose and, if it did, ground 3 challenges the substituted decision. Under each ground a number of criticisms were raised, which I deal with below.

Ground 1

"Materially flawed"

95. This term is not defined in the 2004 Rules. Both parties have referred to guidance in GMC's document "Rule 12: Frequently Asked Questions". Thus, "the flaw must be something of real significance rather than a minor error. The key question to consider is whether, if any identified flaw were corrected, this might have led to a different conclusion." Examples include factual errors, or a failure to consider all allegations. Here AR1's decision had been very finely balanced. AR2 directed herself by reference to the approach in GMC's document, which, in my judgment, is consistent with a proper interpretation of Rule 12 (see also *Zia* and *Rudling*). Mr Kellar QC does not challenge this aspect of the decision.

The gravity of the allegations

96. Mr Kellar QC raises three complaints. The first challenges AR2's assessment that AR1 had failed to appreciate the gravity of the findings made by the Inquiry in relation to the misleading of Mr. and Mrs. Roberts in 2004/2005. He submits that AR1 correctly set out the relevant history, quoted key findings made by the Report on the letter of 12 January 2005, understood that the Claimant had attempted to mislead and/or contributed to the misleading of Mr. and Mrs. Roberts and appreciated that the allegation was serious and at the "higher spectrum" of cases considered by the GMC. AR1 noted that the Claimant was not the main author of the letter and there was uncertainty as to which parts he had contributed.

97. Mr Kellar QC accepts that the meeting in December 2004 and the letter in January 2005 concerned the same subject-matter and formed part of the same sequence of events (paragraph 55b of his skeleton). He goes on to assert that AR1, aware of the Claimant's presence at the meeting on 7 December 2004, must also have been aware of those parts of the Inquiry's Report which had dealt with that meeting. Those submissions are highly significant. At that point in his written argument Mr Kellar acknowledged that the conclusions of O'Hara J on the Claimant's failings in relation to the meeting were also relevant to his contribution to the letter dated 12 January 2005 which followed, in particular on matters within his specialist expertise.

98. Nevertheless, Mr Kellar's submissions fail to grapple with the findings made by O'Hara J regarding the meeting on 7 December 2004 (see [44] to [45] above). The potential relevance of those findings to the view taken by the Inquiry on the Claimant's contribution to the letter on subjects within his specific expertise is clear (see e.g. [46] to [48] above). The Inquiry made similar criticisms of the Claimant in relation to his evidence to the inquest (see [49] above).

99. When the real burden of this criticism of the Claimant is understood, it can be seen that AR1 did not address it in his decision (see [77] above). Indeed, he had thought that the Inquiry's main criticism of the Claimant was that he had not reviewed for accuracy those parts of the letter to which Dr Steen had contributed and which fell *outside* the

areas of the Claimant's specialist knowledge (see [75] above). The Inquiry said no such thing. That plain misreading of the Report would appear to have arisen because AR1 focused on paragraph 3.264 (and indeed quoted it) as if that represented the sum total of the Inquiry's criticism of the letter and the Claimant's involvement in it. That comes from AR1's failure to note that paragraph 3.264(iv) referred to *matters* which had been completely ignored in the letter (of which only one example was given at that stage) and to read the relevant parts of the Report as a whole. Indeed, paragraphs 52(b) and 57 of the Claimant's skeleton contain the same error.

100. In my judgment, AR2 cannot be criticised in relation to her analysis of the Inquiry's Report and the identification of material errors in AR1's decision letter dated 14 November 2018 (see [86] above). AR1 missed out key points and wrongly thought that allegation (1) was really to do with the Claimant's failure to review Dr Steen's contributions to the letter to Mr. and Mrs. Roberts. It certainly cannot be said that AR2 was not reasonably entitled to arrive at those conclusions.

101. The fact that AR1 found that allegation (1) involved the Claimant misleading and/or contributing to the misleading of Mr. and Mrs. Roberts and that it was at the "higher spectrum" of GMC cases is nothing to the point. He reached that view on his mistaken understanding of the criticisms contained in the Report and without appreciating the Inquiry's findings on the Claimant's dealings with the Roberts, both at the meeting and in the letter of 12 January 2005, in relation to electrolyte testing and fluid management, his own area of expertise. Logically the only conclusion that could be drawn is that the allegations arising from the Inquiry's findings were significantly more serious than AR1 had appreciated.

102. Given that AR1 had treated the gravity of allegations (1) and (2) as the only factor supporting waiver of the 5-year rule, and, even on his misunderstanding of allegation (1), had considered the rule 4(5) factors to be very finely balanced, it is obvious that a correct assessment of allegation (1) could result in a decision that the 5-year rule should be waived, even if there had been no other material flaws. That conclusion is reinforced by the addition of allegation (3), as AR2 recognised.

Public confidence

103. Mr Kellar QC submits that there was no material flaw in AR1's assessment of public interest factors, in particular maintaining public confidence in the profession. It is submitted that AR1 correctly referred to the three elements of the GMC's overarching objective, and specifically to maintaining public confidence in the profession and high standards of conduct. Mr Kellar says that AR1 was fully aware of the content and seriousness of the allegations and took into account (a) absence of any ongoing risk posed by the Claimant to the public as regards patient safety and competence, (b) lack of any regulatory or disciplinary history, (c) thorough ventilation of issues in the Inquiry and (d) the Claimant's apology.

104. Accordingly, Mr Kellar QC submits that AR2 was incorrect to say that the assessment of the public interest had been materially flawed. AR1's assessment had not amounted to a "bare statement" and had not failed to assess factors going to the public confidence issue.

105. I can see no public law error in AR2's finding that AR1's assessment of public confidence issues was materially flawed. There was no proper consideration by AR1 of the key point: the duty of candour owed by a medical practitioner when providing sufficient and accurate information to the family of a patient who has died while undergoing treatment in hospital, and to a Coroner investigating that death. Here, the alleged lack of candour related directly to failings in care which resulted in Claire's death. In these circumstances, AR2 was fully entitled to refer to the observation by AR1 that "there may be some public interest in investigating these concerns for protection of the public confidence given the nature of the allegations" as a "bare statement". I endorse AR2's judgment that AR1's reasoning was wholly inadequate to address the issues involved, which were undoubtedly important and sensitive.

106. But AR2's criticism of AR1's decision was rather more fundamental. She said that AR1 had failed to justify his view that public confidence factors were not so significant as to carry any weight in favour of waiving the 5-year rule. I agree with Mr Mant that AR1's conclusion was wholly unsustainable. It shows that his appraisal was tainted by his failure to appreciate key elements of the Inquiry's findings going both to the seriousness of the allegations and the public interest issues involved. Accordingly, the complaint relating to this second aspect must be rejected.

Delay

107. Mr Kellar QC submits that it was unreasonable for AR2 to conclude that AR1 acted illogically by treating the reasons for delay as weighing against waiver of the 5-year rule. He says that all that AR1 was doing was to express a balanced conclusion which weighed the extent of the delay, which was considerable, against reasons which explained that delay.

108. I accept Mr Mant's submission that there is no force in this criticism. In his decision AR1 assessed the "large lapse of time" as pointing against the waiver of the 5-year rule. He then went on to evaluate separately the reasons for the delay. He stated in express terms that "the reasons for the delay" pointed against waiver, albeit "slightly". Logically, that factor could only have pointed in favour of waiver given that it was explicitly assessed as a separate matter. It was illogical to treat that factor as going the other way. His words "on balance" referred to the balancing of the various factors explaining delay, because AR1 considered that "there could have been an opportunity" to raise concerns in 2005 or 2006. The words "on balance" therefore do not refer to a balancing exercise between length of delay and reasons for delay, as Mr Kellar QC suggested.

109. But what if an alternative view were to be taken: namely, that AR1 did carry out a balancing exercise between those two considerations. Given that AR1 accepted that concerns about candour explained why the allegations would not have come to GMC's attention before they had been independently scrutinised (i.e. by the Inquiry), it is difficult, if not impossible, to see why AR1 did not treat those reasons as negating or neutralising the lapse of time, rather than deciding that the outcome of this balancing exercise slightly weighed against waiver. In order to overcome that problem, Mr Kellar QC contended that AR1 also took into account at this stage the prejudicial effect of the lapse of time on the Claimant's ability to respond to allegations. There are three reasons why that submission is untenable. First, AR1 had not yet addressed that subject at all in his decision letter and, when he went on to do so, he gave two different weightings in

respect of that factor, one for allegation (1) and another for allegation (2) (see [75] to [76] above). Second, AR1 decided that evidential prejudice to the Claimant weighed against waiver in relation to allegation (2) but not allegation (1). On Mr Kellar's reading of the decision, that distinction was not applied by AR1. Third, his reading would involve double-counting of evidential prejudice.

110. With respect, Mr Kellar's attempt to explain the reasoning in this part of AR1's decision only serves to show, that even if the court were to reject AR2's "illogicality" criticism, nevertheless AR1's reasoning on this very important factor was, as a matter of law, wholly unclear and defective. It was still "materially flawed" and, on any view, qualified as one of the reasons why AR1's decision needed to be reviewed by AR2 and, indeed, replaced by a fresh decision.

111. Accordingly, I reject the criticisms of AR2's treatment of the delay issue.

Conclusion on Ground 1

112. For all these reasons, ground 1 of the challenge must be rejected. It follows that AR2 was entitled to conclude that there were "material flaws" in AR1's decision on the application of rule 4(5) for the purposes of rule 12 (2) (a).

Ground 2

113. Ground 2 is concerned with the application by AR2 of the public interest criterion in rule 12(3)(c) of the 2004 Rules. Mr Kellar's submissions relate to four aspects.

Fair Hearing

114. AR2 accepted that there was "no flaw" in AR1's assessment of prejudice to the Claimant through the absence of a transcript of the inquest in 2006. AR1 referred to minutes and notes taken during the inquest and the Claimant's inability to say after this length of time whether these notes were accurate. He had not been asked to check them at the time. AR1 concluded that the extent to which evidence is available "could significantly prejudice the Claimant in responding to the allegation, and therefore prevent Professor Young from having a fair and just inquiry into the allegations. This issue would weigh fairly heavily against waiver of Rule 4(5)."

115. Mr Kellar QC submits that the following passage in AR2's decision was inconsistent with her acceptance that AR1's conclusion on this issue was not flawed:-

> "However, I do not consider that the prejudice is such that a fair hearing of an allegation concerning Professor Young's conduct in respect of the inquest would necessarily be impossible."

He accepts that this complaint goes only to the decision to refer allegation (2) to the Case Examiners.

116. I accept Mr Mant's submissions on this point. This was not a case where there was no evidence to support the allegation (cf. paragraph 52 of the GMC's Guidance on Rule 4(5)). The Assistant Registrar had the findings of the Inquiry (see [49] above). The criticism made by the Inquiry is essentially in line with those relating to the meeting with Mr and Mrs Roberts and the letter subsequently sent to them. Mr Kellar's reliance

upon, for example, a note recording an objection to one question in cross-examination of Professor Young does not address the totality of the material before the Inquiry. AR 2 pointed out that that material included a deposition he made to the Coroner (omissions from which were said to be relevant) and emails relating to preparation for the inquiry (see p. 9 of the decision letter dated 9 January 2002 referring to the Claimant's email dated 7 April 2006).

117. AR1 did not conclude that the non-availability of a transcript of the inquest would prevent a fair and just inquiry, but rather that it *could* do so. That is why he treated this factor as weighing "fairly heavily" against waiver, rather than decisively, as would have been the case if he had concluded that a fair hearing would be impossible.

118. Accordingly, there is no inconsistency between AR1's findings accepted by AR2 and the latter's observation that a fair trial would not necessarily be impossible.

119. Paragraph 52 of GMC's "Guidance" also states that Assistant Registrars "are not required to carry out a full evidence gathering process as this will come at a later stage." A full investigation is only carried out where the 5-year rule is not applied. It is for the Case Examiners to consider the evidence and to decide whether or not an allegation should be referred to the Tribunal. Mr Mant told the court that if the Examiners should conclude that a fair trial would not be possible, they would not refer an allegation to a Tribunal.

120. There is no legal basis for saying that AR2's conclusion was inadequately reasoned.

Prior ventilation

121. Mr Kellar QC submits that AR2 failed (a) to engage adequately with the prior ventilation of the allegations and (b) to give adequate reasons on this subject. AR1 concluded that the detailed investigation of these matters by the Inquiry "weighed against" waiver of the 5-year rule, AR2 made no finding of any "material flaw" in that evaluation and so she ought to have applied it when assessing the public interest under rule 12(3) and (6). AR2 simply recorded the Claimant's representations and failed to engage with the point at all. Alternatively, it is submitted that AR2 failed to give legally adequate reasons on this matter addressing GMC "Guidance."

122. I am unable to accept these criticisms of AR2's decision. The claim that AR2 failed to "engage adequately" tacitly acknowledges that AR2 did take this factor into account. Indeed on p.11 of her decision dated 9 January 2020 she did just that. Given that she did not criticise the conclusion of AR1, AR2 should be treated as having acted in accordance with it. There is nothing to suggest the contrary.

123. The "prior ventilation" point appears as one of several factors emphasised in representations made on the Claimant's behalf to AR2. At page 12 of her decision AR2 stated that she had carefully considered all of those points, including prior ventilation. She then weighed them in the balance against the serious gravity of the allegations and the public confidence considerations. She concluded that a fresh decision was required in the public interest, resulting in a referral of the case under rule 8. In her decision dated 23 March 2020 she referred to AR1's reasoning that inquiries such as the one held by O'Hara J may prompt regulatory action in respect of any criticisms made, particularly as the GMC focuses on a different issue, namely impairment of fitness to

practise. AR2 added that the Inquiry had not investigated how any lack of candour might affect fitness to practise, an investigation that could only properly be carried out by GMC.

124. Then AR2 quite properly reminded herself that AR1 had considered the rule 4(5) considerations to be "very finely balanced" when he had treated gravity as the sole factor in favour of waiver. That judgment took into account the weight to be given to prior ventilation. AR2 then pointed out that she was taking into account matters relating to gravity and public confidence which had not previously been evaluated by AR1. She found that the balance tipped the other way. That approach was entirely consistent with the weight given by AR1 to prior ventilation. That is why AR2 said that the prior ventilation in a different forum with a different remit "does not alter that position" i.e., did not tip the balance in favour of applying the 5-year limit.

125. To what extent a decision maker engages with a particular factor is generally a matter of judgment and subject to review solely on *Wednesbury* principles. For the reasons already given, it is impossible to say that there was any irrationality here or that AR2 failed to "engage adequately" with this issue. The reasoning of AR2 reflected paragraphs 66 to 67 of GMCs Guidance on applying the 5-year rule. That states that "the more alternative ventilation there has been, the less compelling is the argument for (GMC) to consider the allegation." But that is not the case where "another body has made findings critical of the practitioner."

126. At the end of the day, the reasoning given by AR2 did not fail to resolve any important issue or to create a substantial doubt that a public law error has been committed (see e.g. *South Bucks District Council v Porter (No.2)* [2004] 1 WLR 257).

The Claimant's regulatory history

127. Mr Kellar QC submits that when assessing the Claimant's regulatory history AR2 took into account an irrelevant consideration, with the consequence that she improperly "marginalised" that factor. Merely giving marginal weight to a factor, without more, does not amount to an error of public law unless irrationality is involved. Mr Kellar QC does not raise that contention. Instead, he criticises the following passage in AR2's decision letter dated 9 January 2020:-

> "Despite Professor Young's positive record as a practitioner, this does not in the case of an allegation such as this preclude a finding of current impaired fitness to practise and it would be for Case Examiners to assess whether or not any allegations, even if found proved, could be and have been remediated."

128. Mr Kellar QC submits that it was irrelevant for AR2 to have regard to a future assessment by the Case Examiners under rule 8, given that their role is different and involves the application of a different test. The Examiners are concerned with whether, after having investigated the allegations referred to them, there is a realistic prospect of proving on a balance of probabilities the allegations and impairment of fitness to practise through misconduct. Mr Kellar submits that AR2 effectively abdicated to the Case Examiners her responsibility for weighing regulatory history in the "public interest" assessment under rule 12(3) and (6). The consideration of regulatory history

by the Examiners in the discharge of their separate functions could not diminish the weight to be given to that factor by an Assistant Registrar acting under rule 12.

129. In my judgment there is no merit in this complaint.

130. As we have seen, AR1 took into account regulatory history as part of his assessment that "the risk to the public" was low (page 9 of the decision letter). In his final conclusions he returned to this subject when he said "important factors here include the low continuing risk" to "public safety" (page 9 of the decision letter). I have already rejected the challenge under ground 1 to AR2's finding that this approach involved a material flaw. AR1 failed to appreciate the significance of the alleged lack of candour in dealings with Mr and Mrs Roberts and the Coroner and, if substantiated, its effect on maintaining public confidence in the profession. Furthermore, the approach taken by AR1 involved giving countervailing weight to patient safety, professional competence and regulatory history, so that the maintenance of public confidence in the profession was not treated as a significant factor supporting waiver of the 5-year rule (see [80] to [81] and [103] to [106] above).

131. It is apparent that in her decisions AR2 gave substantially more weight than AR1 had done to the effect of the alleged lack of candour on maintaining public confidence in the profession. Contrary to Mr Kellar's suggestion, that did not involve diminishing the weight given to the Claimant's regulatory history, along with patient safety and professional competence. It was simply a re-evaluation in which those factors were judged by AR2 to be outweighed by the greater weight now given to the "public confidence in the profession" factor.

132. I also accept Mr Mant's submission that, given her conclusions on the seriousness of the allegations involving lack of candour, AR2 had in mind the well-known principle that matters going to personal mitigation, such as absence of regulatory history, have less significance than the maintenance of public confidence in the profession (see by analogy *Bolton v Law Society* [1994] 1 WLR 512, 519; *Yeong v General Medical Council* [2010] 1 WLR 548 at [19] and [51]; *General Medical Council v Bawa-Garba* [2019] 1 WLR 1929 at [84]; and *Zafar* at [52]).

133. When the sentence in AR2's decision criticised by Mr Kellar QC is read in the light of the paragraph (and indeed the decision) as a whole, it is also plain that AR2 was acting in accordance with paragraph 65 of GMC's Guidance on rule 4(5) addressing regulatory history:-

> "They should also consider any continuing unwarranted risk to public confidence in the profession if the allegation was not investigated."

134. Once these issues are seen properly in context, Mr Kellar's reference to a snippet from the "Frequently Asked Questions" document, referring to evidence that a practitioner has learned lessons from the incidents and taken steps to change his or her practice, is nothing to the point. I also note that, to avoid any misunderstanding, AR2 reiterated the approach she had taken in the last paragraph of section 8 of her decision letter dated 16 March 2020. That approach cannot possibly be impugned.

135. In short, the criticism made of AR2's decision is flawed because it involves reading the short passage quoted in [127] above in isolation and fails to read the decision letter as a whole and in the context of the regulatory scheme. In my judgment, there is nothing in AR2's decision letters to indicate that she failed to discharge her function by leaving evaluation to the next stage under rule 8. She did not abdicate her responsibilities to the Case Examiners. She made her own assessment of the relevant factors which is not open to challenge by judicial review.

Erroneous and unfair reference to a "cover up"

136. Mr Kellar QC criticises AR2 for having suggested that the accusations against the Claimant involved him having knowingly played "a part in a cover up of the magnitude alleged" (see [91] above). He points out that the Inquiry did not make any such finding and its only use of the phrase "cover up" related to Doctors Webb and Steen in connection with the death certificate and autopsy report (see [19] to [20] above). The Claimant, of course, was not involved in those matters. Mr Kellar QC claims that this erroneous use of the term "cover up" amounts to a significant factual misdirection on a matter that was central to AR2's assessment of gravity and the public interest. In addition, he raises a procedural complaint, namely that the allegation of "cover up" was not put to the Claimant during the rule 12 process so that he could respond to it.

137. I accept Mr Mant's submissions on this part of the challenge. The allegation made by Mr. Roberts did use the term "cover up". In any event, AR2 has explained in her decision letter dated 16 March 2020 that the allegations against the Claimant were plainly very serious and involve, at their highest, "an allegation of deliberately misleading the family of a deceased child and a Coroner in relation to cause of death." AR2 recorded the Inquiry's finding that the Claimant had shifted from an initial position of independence to protecting the hospital and its doctors. AR2 considered these to be very serious matters going to the heart of the public's confidence in the profession.

138. In the light of AR2's unimpeachable description of the allegations, the criticism of the use of the word "cover up" has no legal merit at all. But I would repeat that the court is not expressing any view on whether there is any factual merit in these allegations. That is not the court's function in these proceedings. At the present stage they are matters for the GMC.

139. Likewise, the complaint of procedural unfairness is wholly without merit. The GMC has properly made the Claimant aware of the allegations being considered. The use of the phrase "cover up" did not alter the substance of those allegations.

Conclusion

140. For all these reasons ground 2 must be rejected.

Ground 3

141. Here Mr Kellar QC challenges AR2's substituted decision. There are three complaints.

Prior Ventilation

142. AR1 concluded that the prior ventilation of the allegations in the Inquiry was a factor which "weighed against" waiver of the 5-year time limit (see [82] above). Mr Kellar QC submits that, without ever suggesting that there was a "material flaw" in AR1's conclusion, AR2 improperly substituted her own view that prior ventilation did *not* weigh against the public interest. That is based upon the following part of AR2's decision:-

> "Although Professor Young's actions were ventilated during the Inquiry, that ventilation did not include an investigation of the extent of how any dishonesty, its potential motive or a breach of candour may affect Professor Young's fitness to practise. That is an investigation that can only properly and fully be carried out by the General Medical Council, whose remit it is the investigate the fitness to practise of individual practitioners."

143. The passage criticised in fact reflects reasoning contained in AR1's decision. There is nothing to suggest that AR2 altered the weighting given by AR1 to this factor. As previously explained, and as is perfectly clear from AR2's decision, the "public interest" balance changed because of AR1's mistaken appraisal of the gravity of the allegations and the public confidence issues (see [124] above). In relation to the treatment of prior ventilation there is no inconsistency between the views of AR1 and AR2 as Mr. Kellar QC claims. With respect, the point is completely hollow.

Availability of evidence and fair hearing

144. This complaint only arises in relation to allegation (2). It recycles the criticism made under ground 2 that AR2's assessment was inconsistent with that of AR1 on the effect of there being no transcript of the inquest on the Claimant's ability to respond to that allegation and the fairness of any hearing. For the reasons already given under ground 2, there is nothing in this complaint. Furthermore, for essentially the same reasons as those given in relation to the "prior ventilation" issue, the criticism that AR2 failed to give the same weight to this factor as had been applied by AR1 is untenable.

Failing to weigh the extent of the delay in the balance

145. Mr Kellar QC submits that the GMC's Guidance on rule 4(5) indicates that an Assistant Registrar needs to do two things in relation to the extent of any delay: first, calculate the time that has elapsed and second, consider how much weight to give to that period in the evaluation of the public interest factors. He says that AR1 did both. After calculating the lapse of time, he decided that the periods involved "would point against waiving the 5-year rule." Mr Kellar QC submits that whereas AR2 accepted AR1's calculation of the periods of delay, she made no finding on weight, in particular that this factor weighed against waiver.

146. I reject this complaint. AR2 did not criticise AR1's evaluation of the periods of delay or the weight to be given to them. She explicitly referred to the representations on behalf of the Claimant that the lapse of time had been "extreme" (page 11 of the decision dated 9 January 2020). Instead, she criticised the approach taken by AR1 to assessing the "reasons for the delay" as a material flaw. That was an additional factor which has

already been discussed under ground 1. It is impossible for the Court to infer that AR2 did not treat the periods of delay as, in themselves weighing against waiver of the 5-year rule. The point is so obvious that it did not need to be expressly reiterated in AR2's decision.

147. This submission has an air of complete unreality about it. Even with the weight given by AR1 to "extent of delay" as a factor counting against waiver, and even though he considered that the "gravity" of the allegations was the only factor weighing in favour of waiver, he nonetheless judged that his decision not to waive the time limit was "very finely balanced." Not surprisingly, therefore, the focus of AR2's decision was on the weight to be given to important factors which AR1 had omitted and it was unnecessary for her to say anything expressly about the extent of the delay. On any fair reading of her decision letters, AR2 treated that factor in the same way as AR1. It is plain that AR2 struck the "public interest" balance differently because of the weight she gave to factors which AR1's decision had failed to take into account or to grapple with.

Conclusion

148. For all these reasons ground 3 must be rejected.

Conclusion

149. Although Mr Kellar QC has deployed much forensic skill in advancing this claim for judicial review, there is no legal basis upon which the court could possibly interfere with the decisions of AR2 dated 9 January and 23 March 2020 under rules 4(5) and 12 of the 2004 Rules. Accordingly, the claim must be dismissed.