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Case No: CO/11559/07

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 22/05/2009

Before :

MR JUSTICE BLAKE

- -

Between :

Dr. David SOUTHALL	**Appellant**
- and -	
The GENERAL MEDICAL COUNCIL	**Respondent**

- -
- -

Stephen Miller QC and Mary O'Rourke QC (instructed by **Hempsons Solicitors**) for the **Appellant**
Robert Englehart QC and Richard Tyson (instructed by **Field, Fisher Waterhouse Solicitors**) for the **Respondent**

Hearing dates: 31st March, 1st April, 2nd April, 3rd April 2009

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Approved Judgment

The Hon Mr. Justice Blake :

Introduction

1. On the 4th December 2007 the Fitness to Practice Panel of the General Medical Council (GMC) found Dr David Southall guilty of serious professional misconduct and directed that his name be erased from the register of medical practitioners pursuant to Section 36 of the Medical Act 1983 as amended. This is an appeal brought pursuant to Section 40 of that Act in which Dr Southall contends that the panel was wrong to make certain findings of fact that were central to the conclusion of serious professional conduct and was also wrong in the circumstances of the case to impose the most severe sanction available, namely erasure.

2. Dr Southall is a consultant paediatrician of national and international renown. From 1988 until 1992 he was based at the Royal Brompton Hospital London and from 1992 was a consultant at the North Stafford National Health Trust at Stoke on Trent. Until recently he was also a professor of paediatrics at the University of Keele. The events that formed the subject of the complaint of professional misconduct date from the period March 1990 to April 1998. Accordingly the conduct of the disciplinary proceedings was governed by the Professional Conduct Committee (Procedure) Rules 1988 as they stood prior to the 1st November 2004.

3. For reasons for which the court is not concerned, the disciplinary hearing in this case did not commence until November 2006. There were 16 days of hearing in which the complainant's witnesses and then Dr Southall himself gave evidence. The matter was then adjourned and could not be re-listed with the appellant's leading counsel being unavailable until November 2007, a year later. There then followed eight days in which the final witness for the appellant gave evidence and there were closing submissions. The panel considered its decision on the facts for some three days in private session between the 22nd and 26th November. It delivered its decision on the 27th November 2007. There then followed 5 further days of hearing in which evidence was tendered and further submissions were made as to serious professional misconduct and sanction.

4. It is apparent from this brief outline and the transcript of the hearing that this was a demanding and challenging case where the panel members received very considerable assistance from counsel on both sides, asked extensive questions of their own of the key witnesses, and took a considerable time to reach their conclusions after deliberating.

5. It is appropriate at this stage to observe that this was not the first adjudication of the Professional Conduct Committee of the General Medical Council to which Dr Southall has been subject. Following the events with which this appeal is concerned,

in April 2000 Dr Southall made some unsolicited comments in the field of child protection having watched a television programme relating to the case of Sally Clarke and her conviction for murdering two of her baby children. In August 2004 a panel of the GMC found Dr Southall guilty of serious professional misconduct and placed conditions on his medical registration preventing him engaging in child protection work. An appeal brought by the Council for the Regulation of Health Care Professionals against this sanction was heard by Mr Justice Collins and dismissed in April 2005: see *Council for the Regulation of Health Care Professionals v General Medical Council* [2005] EWHC 579 (Admin) 2005; Lloyds Law Reports (Medical) 365. Mr Justice Collins allowed the appeal to the extent of varying the conditions attached to the registration and required a review of those conditions within three years of them being made. The first review of those conditions was due in July 2007 when the present matters were outstanding. By mutual agreement the conditions were extended until August 2008. The court has been informed that on that occasion the panel concluded on the evidence before it that there was no longer any need for conditions and Dr Southall was returned to unrestricted practice.

6. The panel hearing the matter in August 2008 was not concerned with the facts in the present appeal, and the panel hearing the present matter was not concerned with the conclusions in the other case in reaching its factual conclusions. Reference was made to the other case in the context of sanction. It appears that since 1999 by arrangements first with his employer and then subsequently pursuant to the conditions imposed by the GMC, Dr Southall's work has been restricted to general paediatrics and has excluded specialist work on child protection issues.

<u>The allegations against Dr Southall:</u>

<u>(1) The Dinwiddie letter</u>

7. The conduct alleged by the various parent complainants who in form brought these proceedings against Dr Southall can conveniently be divided into three parts. The first and least serious concerns a letter that Dr Southall wrote in March 1990 to Dr Dinwiddie, a treating clinician at the Great Ormond Street Hospital for Sick Children who had referred child H to Dr Southall at the Royal Brompton Hospital because of undiagnosed concerns with the child's respiratory system and problems that the parents were reporting. After a period of investigation the parents declined to have child H further treated by Dr Southall or to use the monitoring equipment that he was supplying for use back home. This prompted the letter in question where Dr Southall stated his opinion that child H's parents were not acting in the child's best long term interests, he was suspicious of their motives and he viewed the child's long term prognosis with great concern.

8. The detailed contents of the letter did not reflect well on child H's parents. However, it was not the content of the letter that was the subject of the disciplinary charges. It was accepted that Dr Southall had genuine child protection concerns (as apparently did others) and was entitled to communicate them both to Dr Dinwiddie, the referring consultant and other clinicians who had treated child H in the past in respect of his respiratory problems. The typed copy of the letter found in the Brompton Hospital files disclosed that the letter was to be copied to:-

i) Dr Bailey, child H's general practitioner

ii) Dr Weaver, a consultant paediatrician at one of two hospitals local to child H's place of residence and

iii) A consultant paediatrician at the Royal Gwent Hospital, which was another hospital in the general locality of child H's place of residence.

It was accepted although there had been no parental consent to copies of the letter being sent to Dr Bailey and Dr Weaver that Dr Southall was entitled to send it to these named physicians because of his concerns. The charge was based on the fact that the letter had been copied and sent to an un-named paediatrician at the Royal Gwent Hospital. Child H had never been treated there, there was no positive indication that he was about to be treated there. It was alleged that considerations that would justify over-riding patient confidentiality when corresponding with named physicians did not exist when corresponding with un-named physicians.

9. Although at one time in the history of these proceedings Dr Southall had through his solicitors admitted that the letter was sent and he indicated that it had been sent with parental consent, that admission was withdrawn. It was accepted that there had been no parental consent for the sending of the letter. It was accepted that sending a letter to an unknown physician was contrary to best practice. There was simply an issue as to whether the complainants had proved to the appropriate standard, namely beyond reasonable doubt, that the letter had in fact been sent at all and/or had been sent without any supplementary identification of who the consultant paediatrician actually was. When giving evidence about this matter in November 2006 Dr Southall frankly accepted that he had no memory as to whether or not the letter had been sent. But he thought that if it had been sent it may well have been supplemented by either a covering letter or a telephone call to the hospital. The evidence before the panel was that Dr Bailey and Dr Weaver had received their copies of the letter; there was no record of it in any file of the Royal Gwent Hospital, but that may have been because there was no file on child H there as he had not been treated there. The evidence before the panel also included a copy of a letter that Dr Weaver wrote in response to having been copied in to the letter to Dr Dinwiddie who was based at the University Hospital of Wales, Cardiff. Dr Weaver wrote to Dr Southall on the 3rd April 1990 in the following terms:

> "I noticed that you also sent a copy to the paediatrician at the Royal Gwent Hospital in Newport so I imagine that the parents have involved yet another paediatrician in child H's care. There are now three district health authorities in South Wales who have some involvement with them"

On 17th April 1990 Dr Southall wrote back to Dr Weaver about the matter without comment on whether he had sent the letter to the consultant at the Royal Gwent Hospital or not.

10. The appellant relies on the fact that two further documents in the file suggest that a letter was not sent to Gwent Hospital as originally intended by the CC reference. First, when writing a report about the case on the 27th June 1991 Dr Southall stated:

> "at this stage we wrote to Dr Weaver, consultant paediatrician at Cardiff, to Dr Bailey the general practitioner and to Dr Dinwiddie the consultant paediatrician at Great Ormond Street Hospital"

11. There is thus no reference to a paediatrician at Gwent being written to. Further, at a case conference convened on the 10th July 1991 at the University Hospital of Wales, Cardiff with respect to the child and continuing concerns as to the parents treatment of him Recommendation 5 was that Caerphilly Minors Hospital Casualty Department and Royal Gwent Hospital be alerted to this case in case Mr and Mrs H should try to present child H elsewhere than to the hospitals already involved in his care. Although the proposal to write to Caerphilly Minors Hospital appears to have been a new one, the appellant submits that there would have been no point in writing to Royal Gwent Hospital if this had already been done the previous year.

12. In my judgment, whatever the answer to the appellant's submission that the panel was not entitled to be sure on the evidence before it that the letter had been sent or had been sent in anonymous form, this allegation taken by itself could not be considered to be one of serious professional misconduct. It was common ground that the parents were making an unexplained issue of the child's respiratory health and showing signs of behaviour consistent with the attention seeking behaviour formerly known as Munchhausen's Syndrome by Proxy (MSBP) and now known as Fabricated or Induced Illness (FII) or its variant Parental Induced Illness (PII). If Dr Southall was entitled to write to other physicians who had not referred the child for his professional assistance because of his legitimate concerns and if there was a reasonable chance that the parents might take child H to other hospitals within their locality to seek inappropriate medical attention by treating physicians who had no knowledge of the background then there was a legitimate justification for departing from the norms of parental confidentiality in the interests of child protection.

13. The resulting letter alerting the hospital was not sent to a named physician but simply to the paediatric consultant, with the risk either that it would not be received by the intended recipient or come to the inappropriate attention of others. This may be inefficiency; a failure to reach best professional standards, and some risk of excessive over-riding of the parents' rights to confidentiality but not in all the circumstances of the case as they were presented to this panel serious professional misconduct. Further the events relating to child H are an example of how an ordinary referral of paediatric respiratory problems in which Dr Southall had expertise, can turn into legitimate child protection issues with concerns with a possible diagnosis of MSPB.

(2) The creation of Special Cases files

14. The second main head of the allegations which it was suggested contributed to the finding of serious professional misconduct concerned Dr Southall's clinical practice in maintaining separate from the main hospital records special cases files on children where there were child protection concerns. The allegations can be summarised from two paragraphs from the relevant heads of charge.

> "10. In the cases listed in appendix 1

a) you created or caused to be created a 'S/C' (special cases) file wherein certain original medical records relating to the child were then placed by you or on your behalf

b) the cited medical record is not elsewhere in the child's hospital medical records.

11. The placing or causing to be placed by you or on your behalf of such cited original medical records in a 'S/C' file.

a) damaged the integrity of the child's hospital records

b) caused any such item to be inaccessible to others involved in the future medical care of the child at that time or in the future."

15. In the event, this allegation was only found proved in respect of two children. First, it was proved in the case of child H, who had been treated at the Royal Brompton Hospital but whose special cases files were moved along with a great many others by Dr Southall from the Royal Brompton Hospital to North Staffordshire Hospital when he moved there as a consultant in 1992. It is relevant to note that this transfer occurred when the paediatric department closed at the Royal Brompton Hospital and Dr Southall and his whole staff relocated to the North Staffordshire Hospital. Child D was a child only ever treated at the North Staffordshire Hospital and a special cases file was prepared for him there, separate from the main medical records at that hospital.

16. It was not disputed by Dr Southall that original medical records not found elsewhere on hospital medical records were kept in a special cases file. It is unnecessary to spell out all the records that were so kept in respect of the two children concerned but they certainly included important medical records about the child's treatment and the views of treating doctors.

17. The respondents relied on the evidence of their expert witness Professor David and Departmental Guidance issued in 1998 but reflecting best practice that should have been operated on earlier as to the central importance of complete and accessible medical records for good medical practice. Dr Southall's response was to accept the principle but deny the allegation of both damage to the integrity of the records and inaccessibility to those who had cared for the child medically by contending first that there were indications in the medical records as to the existence of a special cases file by use of the words SC and a number. Further, Dr Southall submitted that all his medical team who had transferred from Brompton Hospital to North Staffordshire and who all joined North Staffordshire thereafter were well aware of his practice of separating out a special cases file from the main medical records. Members of his medical team would thus have known if they had been approached by a treating physician from another hospital to have looked in the special cases file as well as the hospital records before giving relevant information to another concerned medical person.

18. The panel accepted that not every medical file kept separate from the main medical records would damage the integrity of such records. Apart from temporary cases where monitoring records may be needed to be kept near the monitoring equipment for a particular period, the panel accepted that more long term storage of medical records elsewhere might be justified in particular circumstances if their existence was sufficiently "signposted" in the main medical records itself. Professor David acknowledged as much. However, the complainants relied on the evidence of Mr John Chapman who was appointed Legal Services Manager at the Royal Brompton Hospital Trust in 1994, that is to say two years after the transfer of the special cases file. At various points from 1995 to 2000 Mr Chapman had been attempting to identify all relevant records relating to children treated by Dr Southall at the Royal Brompton Hospital, and in particular child H, but was unaware of the existence of special cases files relating to this child in North Staffordshire and did not know what a special cases file was. The signposting, if any, that there may have been on the face of the main hospital records was thus insufficient to alert and inform the responsible officer who had obligations to search out and either disclose or justify a non-disclosure of records to parents or their legal advisors.

19. There was supporting evidence that in 1991 Professor David who had himself been instructed in respect of child H and legal proceedings and had sought the medical records for the child only received the main records and not the special cases files. Further, Mrs H herself had made unsuccessful attempts from 2000 onwards to obtain special cases files directly from North Staffordshire Hospital Trust once she had gleaned their existence.

20. The appellant's principal submission in respect of this allegation was that the complainants had largely adduced evidence as to the practical difficulties they had encountered in getting access to the records from hospital administrators. They did not call evidence of treating clinicians, who had failed to obtain medical records. The system devised by Dr Southall depended upon clinicians contacting him, or members of his medical staff, for consent to access those records and the medical staff, if not the hospital administrators, would have known where to look for any relevant data. The appellant further submitted that the panel reversed the burden of proof when it indicated that it was not satisfied that there was sufficient signposting in the records.

21. This allegation is certainly more serious than the Dinwiddie letter matter. If it had stood on its own it might well have been capable of constituting serious professional misconduct if proved, because of the importance of complete medical records to medical practice. However, by itself, it is unlikely to be the kind of conduct that could have justified the sanction of erasure of registration.

(3) Interview of Mrs M

22. By far the most serious of the three areas of concern that were before the panel in this case was the allegation relating to Dr Southall's treatment of Mrs M in an interview that he had with her on the 27th April 1998. It was the sufficiency or propriety of the panel's findings in respect of this interview that occupied the greater part of the appeal to this court, and in my judgment, deserves very careful consideration.

23. Mrs M was the mother of two boys born in 1986 and 1988 respectively. The elder boy identified throughout these proceedings as M1 had died tragically on the 3rd June 1996. There was an inquest into his violent and unnatural death that was convened on the 9th July 1996. Mrs M gave evidence at that inquest in accordance with a statement that she had made earlier to the police that she had found M1 suspended by a belt that had been looped round a curtain pole in his bedroom and was round his neck. He was dead when found and subsequent attempts at resuscitation were unsuccessful. M1 had been having disciplinary problems at his school and on the day of his death, which was the first school day after the Whitsun half term break, had been put on headmaster's disciplinary report and his mother had gated him that evening preventing him from going out to play with his friend. There was some evidence that he had been in a depressed state of mind previously. There was some evidence that he had complained of bullying to his mother and others but the school had no evidence that he had been subject to any sustained bullying. The school disputed specific allegations that had been ventilated that a teacher had been indifferent to bullying of M1. The inquest heard that M1 had spoken to two of his school companions on the day of his death indicating that he would not be at school the next day because he was proposing to kill himself. They did not take these threats seriously as similar comments had previously been made without incident.

24. There was an inquest into how M1 came by his death. On the evidence heard, the issue for the coroner was simply whether M1 had intended to take his life when he hanged himself from the curtain pole. The medical cause of death was that the carotid arteries passing to the brain had been compressed by the belt cutting off the blood supply to the brain and death would have occurred following loss of consciousness within a matter of seconds of the compression. The pathologist noted a needle puncture on the inner side of M1's right elbow and attributed these to attempted resuscitation. There was no suicide note and as intentional suicide was rare in a child of such tender years the Coroner was not satisfied to the requisite criminal standard that M1 had intended to kill himself and thus returned an open verdict.

25. Following the inquest in October 1996 the social services department of the county council in question had convened a Part 8 review into the circumstances of M1's death with input from the police, the school and others. No new information came to light as to how M1 came by his death or what may have caused him to kill himself, intentionally or otherwise.

26. In January 1998 some 18 months after M1's death there were concerns that reached the social services department as to the welfare of Mrs M's second son M2. Mrs M was a theatre orderly who worked in the local hospital. Her departmental head Mrs Gray had been concerned at the amount of time off work that Mrs M had been having. She explained to her employers that she had been taking time off work because M2 had been depressed and had made statements to the effect that he might kill himself. It is pertinent to note that the family were still living in the council house where M1 had died and M2 was occupying his brother's bedroom. February 1998 would have been the month of M1's birthday and his brother's death may well have been on M2's mind. In M2's case there were also disciplinary concerns at school and again disputed suggestions that he had been the subject of bullying. In the aftermath of M1's death in August 1996 the family had been referred by the school to family counselling services

where M2 and mother had been interviewed by a child psychiatrist Dr Solomon, who was subsequently to change her name upon marriage and when she gave evidence before the panel was known as Dr Corfield.

27. Mr M had had a volatile relationship with Mrs M who it seems had been the subject of domestic violence over the years, and Mr M had served a prison sentence for breach of a non-harassment and assault injunction granted in family proceedings. There had been a number of reconciliations and subsequent break downs but in January 1998 Mr and Mrs M were living apart.

28. Both M1 and M2 had had a significant number of attendances at GP's and hospital with minor injuries, none of which had raised any suspicions of non- accidental injury at the time. M1 had in the past been taken to hospital with suspected appendicitis and had had his appendix removed although in the event the appendix was normal and this was a false alarm. At the time that M2's case was referred to social services on the 16th January 1998 he was in hospital with suspected appendicitis. His mother had kept him off school as she was concerned as to his health in this respect and there was some report of a black stool, that is to say an indicator of possible intestinal bleeding.

29. M2's case was assigned to a social worker who was to play a critical role in the events that led to the disciplinary hearing against Dr Southall. She was Francine Salem, a social worker of some ten years experience, who had concerns generally as to M2's welfare and in particular as to whether M2 was at risk from his mother as a result of parental induced illness, that is to say whether the mother herself may have suffered from MSBP. Ms Salem was expressing these concerns on the 21st January 1998 in a file note. On the 23rd January she had made a telephone call to Dr Southall at his hospital at Stoke on Trent nearby. Her record of that conversation indicates that Dr Southall supported her concerns and suggested that she needed him on board. It turns out that Dr Southall was well known to Mrs Gray's husband who worked with him in the Stoke Hospital and that prior to contact with social services she had raised her concerns with Dr Southall who had referred her to social services who had accordingly been notified of this matter by another person.

30. On 28th January 1998 Ms Salem and her manager Mr Barclay visited Dr Southall at his hospital. Her file note records that he was "still of the opinion that mother has a Munchhausen's Syndrome" and that there was a high risk to M2 who should be removed straight away. On the 29th January 1998 Ms Salem obtained an Emergency Protection Order from Justices because of concerns of an immediate risk of physical abuse based in substantial part on the advice she had received from Dr Southall. A strategy meeting between relevant agencies had been held on the 26th January and a second such meeting was held on the 29th January when it was resolved that the social services would seek an interim care order pending investigation into various hypotheses of harm that M2 might suffer that included MSPB. In that context Ms Salem had expressed concerns about the circumstances of M1's death. The file note records that the police were to investigate that death further. On 2nd February 1998, on the basis of his conversations with Ms Salem and the information that she had provided him about her knowledge of the family circumstances Dr Southall wrote a preliminary report into M2 reiterating his concerns for his safety if left with his mother. At that time M2 was with foster parents pending the hearing of the interim

care order. On 25th February 1998 there is a file note that Dr Southall had tasked Ms Salem with obtaining information about the observations of the scenes of crime officer and related data from the inquest into M1's death. On 4th March there is a file note indicating that the police were not going to re-open the inquest into M1's death although they would seek some clarification from Mrs M as to how the belt was attached to the pole. In the meantime Dr Solomon had spoken to M2 whilst he was in foster care.

31. There was a hearing before HHJ Tonkins at the County Court as to whether a case for an interim care order had been made out. Dr Solomon gave evidence before HHJ Tonkins in those proceedings. In a very helpful judgment dated 10th March 1998 ten areas of concern or potential concern were identified. The last two being concerns about the circumstances of M1's death and the threat to M2 from his mother. His Honour noted, however, that although those concerns had given rise to the emergency protection order matters had moved on and they were not now the basis for the interim care order. A combination of M2's apparent depression and suicidal thoughts and the potential impact of domestic violence on the welfare of this child meant that the threshold for an interim care order was made out but His Honour refused to make such an order largely based upon the evidence of Dr Solomon that M2 was finding the experience of living away from his mother traumatic and wanted to be back with her. Thereafter M2 was returned to his mother's care and when next interviewed by Dr Solomon appeared to be happier and doing well.

32. It was nevertheless contemplated that there would be further social services investigation into M2's welfare and a possible application for a full care order in due course. A number of experts were to be instructed to assist. Two were experts jointly instructed by the local authority, the guardian *ad litem* and both parents who were separately represented. These were Dr Black, a child psychiatrist and Dr Stevenson, a paediatrician. On the 17th March 1998 Dr Southall was instructed on behalf of the local authority alone to give a medical opinion on matters of concern that were identified in the letter of instruction. Further information including the records of the inquest were supplied to Dr Southall in April. He then indicated that he would like to interview both Mr M and Mrs M at his hospital in connection with his report. He had originally indicated that he would also want to interview M2 but on being informed that M2 had now returned home and another paediatrician was involved did not persist with that request.

33. Mr M was unable to attend the interview through apparent work commitments. Mrs M was informed that she should obtain a travel warrant or assistance from an accompanying social worker to travel to North Staffs Hospital for the appointment on the 27th April. When she arrived for the interview Mrs M was surprised and discomforted to discover that Francine Salem was present in the room with Dr Southall. It turned out that this had been at Dr Southall's request. The reason why he requested her presence and why she agreed to it was explored in some detail in the evidence before the panel. Mrs M indicated that it had not been explained to her precisely why Dr Southall wanted to interview her, but she understood it was connected to a suspicion of the diagnosis of MSBP that was one of the reasons why Ms Salem had sought to remove M2 from her care on the 29th January. Equally there was no explanation, she says, as to why Ms Salem was present or what her role would

be at the interview, and if she had known in advance that Ms Salem would be there given her previous experiences in the interim care hearing she would have asked for her solicitor to be present.

34. The substance of the case against the appellant concerns the manner in which he conducted the interview that followed and what he put to Mrs M. Paragraphs 5 & 6 of the committee's conclusions were in the following terms.

"5. a) for the purpose of preparing your assessment/report you interviewed Mrs M on the 27th April 1998 *admitted and found proved*

b) during the course of such interview you accused Mrs M of drugging and then murdering child M1 by hanging him *found proved*

6. Your actions as set out in 5. b) above

a) were inappropriate *found proved*

b) added to the distress of a bereaved person *found proved*

c) were an abuse of your professional position *found proved*".

35. There was evidence before the panel that following the interview with Dr Southall for one to two hours on the afternoon of the 27th April Mrs M was in a distressed state and made contact with her solicitor, at least by telephone. Mrs Parry, the solicitor, recalled the conversation, which she did not note down, where Mrs M complained. On the following day, the 28th April Mrs M had an interview with Dr Solomon and her case notes were in the following terms

"She found the interview offensive and upsetting. F.Salem also present which she didn't like. Questions like "they didn't do toxicology quite possible you drugged him first". Felt accused of killing M1 and it wasn't about M2 at all. Discuss re: report for court."

36. On 29th April Mrs M had an interview face to face with Mrs Parry. There was a contemporaneous manuscript note kept of the substance and subsequently a fuller typed attendance note of this conversation. The manuscript notes suggest that Mrs M told Mrs Parry that Dr Southall cross-examined her, "accusing her of lying", that the pole didn't break and that Mrs M answered questions as best she could. There were also questions as to whether she could get her hands on drugs at work and the suggestion that she would know how to inject a sedative and whether Mrs M was aware that there were no toxicology reports done on M1. The note concludes by recording

"he then suggested that I killed him and that I either suffocated him, drugged him and then hung him".

37. There was thus evidence that Mrs M's account of this interview and the accusation she says that was made during it, was recorded by Mrs Parry within two days of it taking place. Mrs Parry was concerned as to why Francine Salem was present at the medical interview and complained about that matter. In due course a somewhat unsatisfactory explanation was given to her by the local authority. She received Francine Salem's own notes of the meetings that Mrs M annotated for her next meeting with her solicitor on the 3rd June.

38. Dr Southall accepted that there was a discussion of a number of scenarios as to how M1 came by his death during the course of his interview with Mrs M and that the third scenario concerned M1 being murdered. He denied ever accusing Mrs M of such murder or conducting the interview in an aggressive and hostile manner but accepted that given the subject matter it was perfectly possible that she would have perceived that this was the purpose of his questions. He relied on the note of the meeting taken by Francine Salem which, whilst it referred to the three scenarios, did not make any reference to accusation of murder, nor did it record any inappropriate behaviour by Dr Southall or any distress by Mrs M.

39. The issue for the panel was therefore a question of fact namely whether Mrs M was accused of murder in a hostile and aggressive interview or whether she merely perceived that she had been so accused in such a manner. As to this the panel heard from Mrs M, Mrs Parry and Dr Corfield (formerly Solomon) with the latter two commenting upon and in some way expanding on the context of the notes that they had made. On the other side the panel heard from Dr Southall who gave evidence for a great many days in 2006 and Ms Salem who gave evidence last in the case in November 2007. The rival contentions were the subject of substantial addresses by counsel for the complainants and Dr Southall respectively.

40. The panel's conclusions on this part of the case are in the following terms

> "the panel found Mrs M to be a clear, honest and credible witness. You accused her of drugging and then murdering M1 by hanging. This is supported by the notes written shortly after the interview by Dr Corfield on the 28th April 1998 and Mrs Parry, Mrs M's solicitor on the 29th April 1998. Dr Corfield's hand written note includes the verbatim statement that she says was made by Mrs M 'they didn't do toxicology, it's quite possible you drugged him first' also the panel notes your report where you describe Mrs M as categorically denying asphyxiating M1. As to Ms Salem in many respects the panel did not find her evidence to be wholly convincing".

41. The appellant submits that the panel were wrong to find this serious allegation proved to the criminal standard in the light of the conflict of evidence that was deployed before them. It is submitted:-

i) The supporting evidence identified by the panel did not unambiguously support Mrs M's complaints and taken in the context of the oral evidence and other references in the notes was equally consistent with Dr Southall's case of perceived accusation.

ii) There is no reference to Dr Southall's evidence by the panel in its reasons and they could not have lightly dismissed his evidence on this question.

iii) The panel's comments on Ms Salem were inadequate and unsatisfactory and if anything suggest a misapplication of the burden of proof.

iv) Overall, this court should review the fact finding process for itself in accordance with established principles of appellate scrutiny and conclude that the panel's conclusion on this question of fact was wrong and no adequate reasons had been given for explaining how it came to a lawful conclusion against the appellant.

The proper approach of the court on an appeal

42. Section 40 of the Medical Act 1983 as amended provides for appeals to this court in respect of decisions of this sort that include those where a direction is given for erasure (Section 41(a)). Pursuant to its powers under Section 40(7) the Court on appeal may:

a) Dismiss the appeal

b) Allow the appeal and quash the direction appealed against

c) Substitute for the direction appealed against any other direction which could have been given or

d) Remit the case to the registrar for him to refer it to the panel to dispose of the case in accordance with the directions of the court.

43. A decision on erasure requires a four part process under the 1988 Rules applicable to a case of this vintage. First, the panel must reach conclusions on whether the facts that are in dispute are found proved to the requisite criminal standard. Second, it must consider whether those facts found proved are capable of supporting a serious professional conduct. Third, having heard further submissions and evidence both on serious professional conduct and/or sanction the panel must decide whether it finds serious professional misconduct. Finally, it can decide whether to proceed straight to the question of sanction or adjourn. If it gives directions on sanctions it must decide, having regard to the 2005 Indicative Sanctions Guidance, whether the conduct found proved must be visited with the particular sanction that is imposed for the protection of the public and the vindication of the reputation of the profession. In reaching a conclusion on erasure, it would have concluded no lesser sanction will suffice.

44. Each of these four steps can be potentially the subject on appeal. CPR 52.11(1) and the accompanying practice direction makes it plain that such an appeal is by way of re-hearing and

"The appeal court will allow the appeal where the decision of the lower court was -

"a) wrong or

b) unjust because of a serious procedural or other irregularity in the proceedings in the lower court.

The appeal court may draw any inference of fact which it considers justified on the evidence".

CPR 52.11 (3) and (4)

45. The proper approach for this court has been spelt out recently by the Court of Appeal in the case of *Meadow v General Medical Council* [2006] EWCA Civ 1390 reported at [2007] QB 462. I have had regard to the whole of the relevant passage in the judgment of Lord Justice Auld from paragraphs [117] through to [129]. It is clear from this judgment that the test is whether the decision below was wrong. This is a more intrusive appellate function than that deployed in judicial review where the question is limited to whether the decision was reasonably open to the tribunal below. However, it is also plain that this re-hearing will normally take place on the basis of the documents only, where no fresh oral evidence is admitted or tendered. In those circumstances the court must be conscious of the considerable advantage enjoyed by the tribunal below of hearing the witnesses and forming an impression as to their credibility and reliability that is not open to the appeal court. Depending upon the context of the subject matter in dispute, the panel may also enjoy particular professional expertise in the assessment of clinical or related medical issues that will not be within the court,s experience. Accordingly, as Lord Justice Auld said at [128]

> "but even when a review is a full re-hearing in the sense of considering the matter afresh if necessary by hearing oral evidence again and even admitting fresh evidence the appellate court should still, …, give to the decision of the lower court the weight it deserves. This elasticity of meaning in the word re-hearing should apply also to the same word in the practice direction. It all depends upon the nature of the disciplinary tribunal the issue determined by it under challenge the evidence upon which it relied on doing so how the High Court should approach its task whether the decision of the tribunal was 'wrong' and whether on the way to reaching such a conclusion it draws pursuant to CPR 52.11 (4) 'any inference of fact which it considers justified on the evidence'".

46. It is clear that the relevant rules under which this hearing was conducted did not expressly require the panel to give reasons for its decision. Equally it is apparent that common law fairness has supported a requirement of giving reasons wherever it was necessary to show that the panel has addressed its mind to the relevant issue decided

the essential points in dispute and indicated how it reached its decision in order for the unsuccessful appellant to know why he lost. I am indebted to an invaluable review of the authorities conducted by Mr Justice Cranston in the case of *Cheatle v General Medical Council* [2009) EWHC 645 (Admin) and I accept the continued application of the guidance in De Smith's Judicial Review 6th Edition 2007 quoted at paragraph [29] of that judgment namely:

> "The reasons must show that decision maker successfully came to grips with the main contentions advanced by the parties and must tell the parties in broad terms why they lost or as the case may be won".

47. In paragraphs [30] and [31] Mr Justice Cranston quoted the decision of the Privy Council in *Gupta v General Medical Council* [2001] UK PC 61; [2001] 1WLR 1691 and the case of *Phipps v General Medical Council* [2006] EWCA Civ 397; [2006] Lloyds Reports (Medical) 345. It is clear from those decisions that generally speaking the panel need not give reasons for its findings of fact but reasons would normally be required for its findings of serious professional misconduct or the need for a particular sanction. The decision in *Gupta* itself from paras [10] – [13] explained why detailed reasons on findings of fact are not generally required. First, the procedure for identifying with particularity the factual allegations in professional misconduct proceedings adopted by the GMC and/or its panels sufficiently identify what has to be proved and what the panel has accepted has been proved in particular cases. Secondly, as recognised by the European Commission of Human Rights in *Wickramsinge v United Kingdom* [1998] EHRLR 338 the fact that the practitioner can study a transcript of the hearing, including not only the evidence but the submissions on the evidence by the respective parties, further assists the practitioner in understanding not only which witnesses evidence can be accepted and which rejected but why it did so. This learning has now been reflected in amendments to the procedural rules applying to contemporary cases. However, in particular contexts, even findings of fact may require brief reasons to be given to explain how central disputes were resolved and why.

48. In the present context, in my judgment, where there is a sustained challenge to a critical finding of fact by the panel, it is incumbent on the court to examine with care the evidence that was deployed before the panel, the documentary evidence that could either support or undermine such evidence, the testing of such evidence by cross examination from the opposing side or the questions posed by the panel itself, and the submissions that were deployed by the opposing parties as to the credibility and reliability or otherwise of the particular witness in question. If it is apparent from all this material how the panel reached its findings on fact the court does not require reasons for that conclusion because they will be readily inferred. If it is not clear, or there was some substantial submission made as to why a particular piece of evidence could not be accepted, the panel would normally be expected to provide some brief indication of its decision-making in this respect. The court will reach its conclusions on appeal having regard to the materials placed before it and consider whether in all

the circumstances in the light of the need for reasons or any reasons given the panel were wrong to reach the conclusions that they did.

49. In my judgment, applying those principles to the three factual issues in dispute in the present appeal it is only in respect of the dispute as to the fact finding on the evidence in the case of Mrs M that an intrusive examination of the materials and the reasons given for the decision was required in the interests of fairness. The panel started its consideration with the case of Mrs M and went on to reach its conclusions in the other two areas. In my judgment it was right to do so and that is the course this court will adopt on appeal.

Conclusions on the factual foundation of the Mrs M case

50. Mr Miller QC for the appellant in his extensive grounds of appeal, skeleton argument and oral submissions relating to this part of the case identifies a number of features why a panel could not, consistent with the criminal standard of proof, have preferred the evidence of Mrs M and rejected the evidence deployed on behalf of the appellant. In essence these submissions may be reduced to the following propositions:-

i) There was an independent professional witness present at the disputed interview, namely Francine Salem. Her notes of the hearing and oral evidence did not support the core allegations of Mrs M. The panel could not dismiss Ms Salem's evidence and gave no proper reason for doing so and on that basis only there must be a doubt.

ii) There were some inconsistencies in Mrs M's evidence, notably with respect to whether she was distressed during the interview or after it : whether she queried why the social worker was present; whether she made reference to whether a social worker had been present at an earlier interview with Dr Black; whether she had seen her solicitor in person that evening; and whether she had been given an opportunity to answer questions or had been interrupted in her answers by Dr Southall.

iii) Some of the documents relied upon by the Tribunal as supporting Mrs M's evidence also supported Dr Southall's. Notably Dr Corfield's manuscript note of what Mrs M had said to her on the 28th April including the words she felt she had been accused which is different from actually being accused.

iv) If Mrs M had been complaining of being accused of murder it is improbable that neither Mrs Parry, the solicitor, nor Dr Corfield, the consultant psychiatrist, would have failed to express disapproval of this conduct and in some way complained about it. But neither did so. Mrs Parry's letter of complaint was about the presence of the social worker and not the manner in which Dr Southall conducted the interview.

v) The particulars of charge alleged that Dr Southall accused Mrs M of sedating or drugging M1 before hanging him, but part of Dr Southall's concerns about whether the inquest had properly identified the cause of death, and whether Mrs M's account was reliable, was that her account of hanging from a curtain pole was improbable as the curtain pole would have been unlikely to sustain

the weight of a 30 kilo child for any length of time let alone the additional weight of a mother trying to pull the child off the pole. It was therefore inherently unlikely that Dr Southall would accuse Mrs M of doing something that he thought probably did not occur.

51. For the respondent, Mr Englehart QC points out:-

i) The panel found Mrs M to be a credible witness and that is not the subject of challenge in this appeal. Minor inconsistencies on secondary matters do not therefore have any significant impact upon the reliability of her account of the critical matters in dispute.

ii) By contrast with Mrs M whom they found to be an impressive witness, the panel did not find Ms Salem to be a convincing and therefore a satisfactory witness on the issues. The questions that the members of the panel themselves posed of Ms Salem show that they were troubled by her inability to remember any of the details as to how Dr Southall went about what in her words was a "discussion" of the hypothesis of murder, and yet had independent recall of the tone and general attitude of Mrs M and Dr Southall during the interview.

iii) The panel was entitled to treat the evidence of Dr Southall and Ms Salem in context, when it was apparent from January 1998 onwards they had both very readily and on no reliable material reached a conclusion that M2 was at risk of physical harm from Mrs M because of what she may have done to M1 despite the previous investigations into M1's death. It was apparent from the available records that the purpose of the interview was to challenge Mrs M's account of M1's death and the plan for future action drawn up by Dr Southall and Ms Salem after the interview was all essentially directed to producing evidence to support such a challenge.

iv) Dr Corfield in her evidence had carefully explained how part of her note was an assumption or her own summary of the gist of what was being told to her and part was direct verbatim quotation. The words "felt she was being accused" were Dr Corfield's own rather than quoting words being used by Mrs M.

v) The point about failure of either Dr Corfield or Mrs Parry to complain promptly about Dr Southall's conduct of the interview is irrelevant as to what happened at that interview. Mrs Parry's notes of the 29th April show beyond doubt that she was recording a complaint of accusation of murder by drugging and hanging and yet did not register a complaint against Dr Southall. Doubtless at that stage in the procedures much depended upon what he would say in his report and the future of the then contested litigation relating to M2.

vi) At the disciplinary hearing Dr Southall never challenged that the cause of death was hanging. The pathological evidence was entirely consistent with death by suspension. Whatever doubt Dr Southall may have had about the capacity of a curtain pole to hold up a child's body was irrelevant to his belief that Mrs M had murdered M1 first by drugging him and then killing him by

use of the belt round the neck in a manner that caused the injuries observed by the pathologist.

52. Having carefully reviewed all the documentary material before me that touches upon these questions, and reminding myself of the considerable advantage that the panel had in assessing reliability of the respective witnesses as well as their general credibility, I prefer the submissions made on behalf of the respondent.

53. Although Dr Southall was not charged with misconduct in respect of his preliminary opinion of February 1998 or his oral advice to Ms Salem on the telephone in January 1998, I am struck by the alacrity and the weight given to the hypothesis that M1 died as the result of the physical harm inflicted upon him by his mother, whether or not she was suffering from FII or Munchhausen's Syndrome by Proxy at the time.

54. M1's injuries and the cutting off of the supply of blood to the brain by pressure on the carotid artery from the belt was entirely consistent with hanging, that is to say suspension from a fixed point rather than strangulation or direct pressure on the wind pipe, where there was no evidence that it was damaged or bruised. Dr Southall was wrong in his preliminary assessment that hanging is an unusual form of self-harm adopted by ten year old children who inflict harm on themselves. This was recognised in his subsequent report in May after other experts had pointed out the statistical data to that effect. Doubtless, as everyone had pointed out, it is comparatively rare for children as young as ten to take their own lives at all, but that has happened and although there was no suicide note there was direct evidence adduced at the inquest that M1 had told two of his school friends that he was going to kill himself that night. The fact that the belt M1 used to hang himself appeared to have been an adult belt in size in no way undermined the proposition that he had selected it for use. Mrs M had consistently explained that it was M1's belt and he had been given it, that even if he had selected someone else's belt that provided no reason to undermine the inquest conclusions that it was self-harm, albeit that the intention to kill himself had not been proved to the requisite criminal standards.

55. Dr Southall's interest in the load-bearing capacity of curtain poles was outside his area of professional competence as a paediatrician. Having identified this feature he persisted with it as a basis for rejecting Mrs M's account despite the fact that the inquest papers revealed that the scenes of crime officer called to M1's had visited the bedroom where M1 died and had seen the curtain pole for himself having heard the mother's account that she had taken him down from that place. It excited no suspicion in his statement or any suspicion in the police who subsequently investigated the matter both before and after the inquest and re-examined it in the light of Dr Southall's concerns in January and February 1998. There was nothing problematic about how the belt was attached to the curtain pole. Mrs M had described in her witness statement before the inquest that it had been looped over the pole rather than knotted and that is what she consistently described when she was asked to give a demonstration in the interview before Dr Southall. It is an obvious way in which to attach the belt to a pole and not beyond the competence or imagination of a ten year old boy to do.

56. The hypothesis of Dr Southall that M1 might have been drugged before he died and that would explain absence of signs of struggle is, of course, the sheerest speculation resulting from the earlier speculation inconsistent with the evidence presented at the inquest that his death was not self inflicted. Although attention had been drawn at various times to the puncture mark on M1's elbow and in his final report in May Dr Southall recognised that it was probable that this was caused by resuscitation attempts by ambulance crew or hospital staff, he appears to have given no attention at all to the evidence of the pathologist at the inquest that was expressly in those terms. The absence of toxicology tests on M1 was entirely a matter for the pathologist or forensic investigators at the time of the inquest. As there was no reason whatsoever to imagine that M1 had been drugged or sedated, the absence of such a report gives no rise to inference whatsoever.

57. I well understand that a paediatrician concerned with the welfare of the child is not bound by previous conclusions of social workers, police, coroners or anybody else with respect to injuries on a child he is examining or even a sibling of that child. Matters that are properly recorded in medical notes or substantiated by other evidence can properly form the basis of conclusions by an expert paediatrician. It may be that it is considered by reason of his or her experience in assessment of such cases that such injuries were not accidental, or that a sequence of innocuous injuries, however caused, may point to real concerns as to the treatment of the child whether physical or emotional in the home environment where he was at the time. The difference from wholly proper investigative concerns of alternative scenarios in such a case is that they are founded on evidence and the proper experience of the expert evaluating such evidence within his or her area of competence. In this case Dr Southall was not an expert in curtain poles or pathology or it appears the means by which young people may choose to harm themselves once they had decided to do so. In this case not only was there no evidence to support the hypothesis that M1 had not self harmed, but all the inquest evidence pointed the other way. Dr Southall's initial instincts in January and the matters that he put to Mrs M in interview in April were deployed without there being any change in the evidential position adduced before the inquest. Nothing new or suspicious had emerged.

58. Since Mrs M had given a full account in her witness statement to the police and her evidence at the inquest of all these matters and there was nothing in the related evidence to undermine that evidence or suggest it was wrong, in my judgment it was surprising that Dr Southall chose to interview Mrs M on this topic at all. I can well understand why there may have been legitimate concerns as to the emotional welfare of M2 in his family circumstances in January 1998, but that would have focused upon why M2 was either depressed or expressing intentions to self-harm which others were dealing with and Dr Southall did not consider the reason he had been instructed. It was further surprising that Dr Southall was prepared to interview Mrs M on this aspect of the case when he had been told by the social worker that the police were re-examining their investigation in the light of his earlier concerns. He did so without explaining in advance to Mrs M what the purpose of his interview would be, or indicating that she might wish to be accompanied by her solicitor or have other independent support.

59. It is particularly surprising that Dr Southall should consider it appropriate to invite Ms Salem to sit in on the interview. She had been responsible for removing M2 from Mrs M's care in January and could not be regarded as someone who would give moral or emotional support to Mrs M in what undoubtedly would be a stressful interview given the topics that Dr Southall intended to address. His answers during the hearing as to why he asked for Ms Salem to be present were unsatisfactory. It seems it was in part to protect himself and in part because Ms Salem had greater knowledge of the case and could supply information of assistance to Dr Southall. Ms Salem when asked the same questions responded that her presence was principally a matter for Dr Southall's judgment. But she saw the utility of being present even when potential medical competencies were being discussed, as that would save Mrs M the need to attend a second interview with Ms Salem. She, at least, recognised that there should have been some introduction as to why she was present and an opportunity afforded to object.

60. None of these matters above formed the basis of any particular allegations in the charges before Dr Southall. They were, however, in my judgment matters to which the panel could have had regard when considering the preamble to this interview, and the extent to which Ms Salem could be said in the particular circumstances of the case to be independent of Dr Southall.

61. Although Ms Salem's typed up note based upon her manuscript notes of the interview captured many of the topics discussed by Dr Southall and the broad sequence he employed, the panel, in my judgment, was entitled to be concerned by the absence of any detail in the note as to how the scenario of murder was discussed, and any reference to the tone of the exchanges or the emotive responses if any of Mrs M. It is plain that Ms Salem thought that Dr Southall was to be admired for his frankness for investigating these matters with witnesses, and had accepted in cross-examination that he challenged her evidence although subsequently gave a somewhat peculiar explanation of what she meant by challenged. I do not accept that the panel was bound to give weight to the evidence that if Dr Southall had been behaving in the manner alleged by Mrs M, Ms Salem would have complained about it. The perception of whether a line of questioning is improper may depend upon the experience of the observer, her understanding of what was being investigated and why, and her relationship to the person asking the questions. Even in the field of criminal law where a solicitor attends an interview in order to protect the interests of his clients, the courts have known cases of failure to object to oppressive questioning because the solicitor did not consider it his function to do so at the time: see *R v Paris v Ors* [1993] 97 Cr App R 99 at 110.

62. The panel found support in Mrs M's evidence in Dr Southall's own written report of the 20th May 1998. It is quite clear that report spelt out in unambiguous terms that he could not believe important parts of her evidence about not witnessing injections in her work as a theatre orderly and the weight that a curtain pole could bear. As Mrs M had told her solicitor he had disbelieved her on these issues before she had seen the report, this gives some support to her contention that he made it plain that he disbelieved her in the interview. Moreover, the use of the words Mrs M was "absolutely adamant" and "remained adamant" that the belt belonged to M1 is some indication that she had been challenged on those matters by Dr Southall.

63. Further, the report is of assistance in addressing Mr Miller's submission that Dr Southall would not have accused Mrs M of murder by hanging. It states:-

> "The third possibility was that Mrs M had killed M1. A discussion ensued about this including the concept that at ten years old it would be quite difficult to deliberately suffocate or asphyxiate M1 and then pretend to hang him. Probably some form of sedation would be involved. Mrs M had assumed that this had been excluded at the post mortem. Professor Southall pointed out that he could not find any evidence as to whether or not toxicological analysis had been undertaken on M1 after his death. Mrs M categorically denied asphyxiating M1 and reiterated her view that he deliberately killed himself because of bullying by pupils at the school and by his teacher ".

64. First, it was clear that what was being discussed was that Mrs M killed M1 and not merely a general hypothesis of non-self-harm. Secondly, the discussion about this was of deliberate suffocating or asphyxiation and then pretending to hang him. The fact of hanging was therefore not the problem but whether there was suffocation or asphyxiation beforehand to make it look like self-harm rather than murder. Thirdly, a categorical denial of this scenario is highly consistent with an allegation being put that leads to the denial. The denial was both of the allegation of asphyxiation and the suggestion that he hadn't killed himself because he hadn't been bullied. The categorical denial is also consistent with Ms Salem's typed notes of the interview in which she recorded Mrs M saying she would talk about the belt around M1's neck "if it cleared her name" and "as she felt she wanted to prove her innocence". No-one could have challenged her innocence apart from Dr Southall.

65. In my judgment, therefore, the panel were fully entitled to reach the conclusions it did in respect of the case of Mrs M. Its conclusions are sufficiently explained both by the reasons it gave and the detailed scrutiny of the transcript that the court has been invited to undertake. It was entitled to conclude that Mrs M was an impressive credible, and reliable witness in the central issues of the case. There is no reason to conclude that the panel misdirected itself, took account of extraneous circumstances or had failed to remember or give appropriate attention to the evidence of Dr Southall when it reached its conclusions a year later. Dr Southall would have been well aware why he lost.

Conclusions on the factual foundation of other parts of the allegations

66. A detailed scrutiny of the evidence and the submissions relating to other parts of the fact finding is not necessary. Dr Southall's contentions have already been summarised above and they were renewed on appeal.

67. In my judgment, the panel was fully entitled to reach the conclusion that the Dinwiddie letter had been sent to the unnamed consultant as indicated in the copies

sent to the other named physicians, despite the fact that no copy of it was found on the hospital files and it did not seem to have excited a response of any sort.

68. Further, I have no hesitation in reaching the conclusion that the panel was entitled to conclude that the integrity of medical records was compromised by Dr Southall's practice of maintaining special cases files. It was apparent that there was insufficient internal sign posting to direct a person from the main medical files to the special files. The fact that the hospital's records administrator was unaware of the existence of the special cases files, and what any available markings on the main medical files may mean is cogent evidence in this respect. The integrity of the records is vital not merely for future treating physicians but equally for medico-legal and related questions. If the records are incomplete without any signposting of that fact problems are likely to arise of the sort that did arise in the case of child H. Moreover, it was not necessary for the complainants to establish that future treating physicians had actually been misled by the state of the records, it was sufficient that this was a likely consequence of having incomplete records. In my judgment the panel was neither diminishing the criminal standard of proof nor reversing the burden of proof when it commented that it did not accept Dr Southall had made sufficient arrangements to prevent this consequence.

Determination on Serious Professional Misconduct and Sanction

69. Mr Miller QC accepted that the conclusion of serious professional misconduct could only be revisited on appeal were his submissions as to the factual foundation of the findings in the M case successful. They have not been. Taking the findings on the case of Mrs M alone, as well as in conjunction with the conclusions reached below, the panel was fully entitled to conclude that serious professional misconduct was made out.

70. The panel's reasoning as to sanctions was in the following terms:

> "The Panel is in no doubt that it is necessary to take action against your registration and that the sanction imposed must mark strong disapproval of your behaviour. Given the serious nature of your misconduct the panel has determined that to conclude this case without making any direction in respect of your registration or to issue a reprimand would not be sufficient.
>
> The Panel next considered whether it would be sufficient to impose conditions on your registration.
>
> The Panel is aware that you are a paediatrician of international renown and that you have contributed significantly to the field of paediatrics and child protection.
>
> The Panel recognises that your misconduct has arisen as a result of the child protection work that you were undertaking at that time and that your actions, although clearly misguided, may have been motivated by a concern to protect children.

There is no evidence before the panel to demonstrate that your actions have caused direct harm to patients or their families other than in cases involving child protection. Since your reinstatement in 2001, following suspension by your trust, you have not worked in child protection. You have complied with the conditions to which your registration has been subject.

The Panel has been provided with testimonials indicating that you are held in high regard by your professional colleagues. The testimonials highlight your clinical skills and commitment to the welfare of children. They also indicate that you have undertaken important ground-breaking research which has influenced how the medical care of babies and children has been managed both in the United Kingdom and internationally.

The Panel has heard evidence from Dr Park, a consultant paediatrician at the hospital of North Staffordshire and from Dr Bridson, a recently retired consultant paediatrician and chairman of the Trustees of the Child Health Advocacy International, a charity founded by you. Dr Park has given evidence about your outstanding clinical ability and your compliance with the conditions currently on your registration. He also informed the panel that numerous letters of support and thanks from your patients have been received. Both witnesses confirm that they were aware of the findings of fact made by this panel. Nevertheless they remain confident in your clinical abilities. The panel has also considered carefully the evidence given by Dr Chipping, medical director at the time, to the Professional Conduct Committee in August 2004 and her testimonial dated the 16th November 2006. She holds in high regard your clinical skills and the contribution you have been making to the paediatric team at North Staffordshire Hospital.

The Panel has noted the determination of the Professional Conduct Committee in August 2004, the judgment of Mr Justice Collins in April 2005 and the determination of the fitness to practice panel at the review in July 2007.

The Panel has been mindful of Lord Bingham's well known observation in the case of *Bolton v The Law Society* adopted in the case of Dr Gupta, as noted in the Indicative Sanctions Guidance:-

'a profession's most valuable asset is its collective reputation and the confidence which that inspires…..The reputation of the profession is more important that the fortunes of an individual member….. Membership of a profession brings many benefits, but that is part of the price.'

The Panel also had in mind Lord Hoffman's judgment in Bijl v General Medical Council [2002] Lloys Med Rep 60, in which he said:-

'The Committee was rightly concerned with public confidence in the profession and its procedures for dealing with doctors who lapse from professional standards. But this should not be carried to the extent of feeling it necessary to sacrifice the career of an otherwise competent and useful doctor who presents no danger to the public in order to satisfy a demand for blame and punishment…..'

Having considered all the evidence that is before it, the Panel accepts that were your registration to be restricted by tightly drawn conditions, patients would be unlikely to be at risk. However, in considering the maintenance of public confidence in the profession and the declaring and upholding of proper standards of conduct and behaviour the Panel has concluded that the imposition of conditions would not reflect the gravity of your misconduct. Your multiple failings over an extended period caused the Panel great concern. Furthermore, the Panel is influenced by the fact that, although the events in the current case predate those in the Clark case, there are now two instances where without justification you have accused a parent of murdering their child. The Panel has therefore determined that to impose conditions on your registration, no matter how tightly drawn, would not be sufficient to protect the public interest.

The Panel next considered whether a period of suspension would be appropriate. It has carefully balanced the public interest against your own interests. It has taken into account the aggravating features of this case and the mitigation that has been advanced by you. The Panel is particularly concerned by your lack of insight into the multiplicity of your failings over a long period. The Panel is aware that an apparent lack of remorse should not result in a higher sanction but it has noted that notwithstanding the findings of fact you have not either directly or through your counsel offered an apology to any of the Complainants for your actions nor has there been any acknowledgement by you as to your failings.

In all the circumstances the Panel has concluded that you have deep seated attitudinal problems and that your misconduct is so serious that it is fundamentally incompatible with your continuing to be a registered medical practitioner.

The Panel therefore directs that your name be erased from the Medical Register. The Panel is satisfied that this is necessary in

> the public interest for the maintenance of confidence in the profession and in the interests of declaring and upholding proper standards of professional conduct and behaviour."

71. It is not suggested that this analysis reveals any misdirection of law or misapplication of the Indicative Sanctions Guidance. Nevertheless it is submitted that I should conclude that the panel was wrong to direct that nothing short of erasure would suffice to maintain public confidence in the profession.

72. As the panel's reasons indicate there was substantial mitigation here. I consider the following factors to be of particular weight:-

    i. The conduct related to events beginning in March 1990 and concluding in April 1998. This was both a substantial time ago, and was well before the events of 2001 for which he received the lesser sanction of conditions attached to his registration.

    ii. He was a highly skilful paediatrician, save in the field of child protection, where had not practised since 2001 and arrangements could be made for the future to ensure that he would never practice in that field of paediatrics. It would be wrong to deprive the public both in the UK and abroad of the benefit of his skills and experience in the broader field.

    iii. This was not a case of clinical incompetence, dishonesty or other conduct of such a scandalous nature as to be incompatible with continued membership of the medical profession. This was an overstepping of the boundaries of how a paediatrician with child protection concerns should function, prompted by concern for the welfare of the child.

73. It is apparent from my earlier summary of the Dinwiddie and Special Case letters that I do not consider the substance of that conduct either alone or together could have properly sustained the sanction of erasure, however serious a view the panel was entitled to take of the undermining the integrity of medical records. Even so, the conduct proved demonstrated over a period of time, a failure to strike the appropriate professional balance between respect for the position of the parent and any legitimate child protection concerns arising in the course of clinical treatment or examination.

74. The conduct with respect to Mrs M, however, is of a different order altogether. It is truly shocking that it should have occurred. The unjustified accusation of murder made in the circumstances described above, was an abuse of the role of consultant and expert instructed in ongoing litigation. The panel in its reasoning referred to the letter of the 17th March 1998 from the solicitor to the county council instructing Dr Southall to make an expert assessment in that case. The following extracts are of significance:-

"To assist I am enclosing a note of the general accepted principles of what is expected of you as an expert in these proceedings. It is important that the parties are confident

> of your independent status and there are no informal unrecorded conversations with any professionals involved in the case…."
>
> "In preparing your report could you particularly address the following issues:
>
> 1. The implications of the family's (including both parents and M1's) medical notes in the context of the functioning and history of this family and the possible implication for the care of M2…
>
> Could you please ensure that your opinion is confined to the medical issues…"

75. By reason of its findings of fact the panel was entitled to conclude that the sensible guidance in this letter of instruction had been disregarded by Dr Southall. He was speculating on non-medical matters in an offensive manner entirely inconsistent with the status of independent expert.

76. In the end, after very considerable reflection of all the circumstances of the case, and despite the persuasive factors mentioned at [72] above, I am satisfied that the panel was entitled to reach the conclusion that nothing less than erasure would suffice to maintain confidence in the medical profession in general and the specialist discipline concerned with the difficult task of giving expert evidence in child protection cases in particular. Dr Southall's conduct was not a mere error of judgment in a challenging environment where there may have been few established principles for guidance. Nor was this a one-off failure with respect to the treatment of parents whose conduct had come under scrutiny. Public confidence in the science of expert assessment in those cases where serious issues of child protection were indeed raised would be undermined, if egregious behaviour of the kind under consideration here when combined with the lack of insight into or acknowledgment of its nature and extent was considered to be compatible with continued registration as a medical practitioner. I therefore conclude that the panel was not wrong to impose the sanction that it did. This appeal is therefore dismissed.