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IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

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KING'S BENCH DIVISION
(JUDICIAL REVIEW)

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IN THE MATTER OF AN APPLICATION BY ALAN ROBERTS FOR LEAVE TO APPLY FOR JUDICIAL REVIEW

ALAN ROBERTS

Proposed Applicant;

and

GENERAL MEDICAL COUNCIL

Proposed Respondent;

and

PROFESSOR IAN YOUNG

Notice Party.

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Mr McQuitty KC (instructed by Phoenix Law, Solicitors) for the Proposed Applicant
Mr McAteer KC (instructed by Cleaver Fulton Rankin), Solicitors for the Proposed Respondent
Mr McGleenan KC (instructed by Carson McDowell Solicitors) for the Notice Party

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McBRIDE J

Application

[1] The proposed applicant, Mr Alan Roberts, seeks leave to judicially review two related decisions of the General Medical Council ("GMC") in which the GMC decided not to refer allegations about Professor Ian Young to the GMC Tribunal for formal adjudication.

[2] The first impugned decision was made under Rule 8 of the GMC (Fitness to Practice) Rules 2004 ("the 2004 Rules") on 14 February 2023, when the case examiners ("case examiners") decided not to refer allegations against

Professor Young to the Medical Practitioners Tribunal ("the Tribunal") for adjudication - ("the Rule 8 decision").

[3] The second impugned decision was made by the GMC assistant registrar under Rule 12 of the 2004 Rules, when the assistant registrar decided that there were no grounds to review the Rule 8 decision - ("the Rule 12 decision").

[4] It was agreed by the parties that there should be a rolled-up hearing.

Representation

[5] Mr Roberts was represented by Mr McQuitty KC. The GMC was represented by Mr McAteer KC and Professor Ian Young was represented by Mr McGleenan KC.

[6] The court wishes to express its thanks to all parties for their detailed and well-researched skeleton arguments which proved to be of much assistance to the court.

The parties

[7] The proposed applicant (referred to in this judgment as "the applicant") is the father of Claire Roberts, who died in the Royal Victoria Hospital for Sick Children on 23 October 1996.

[8] The proposed respondent is the GMC (referred to in this judgment as "the respondent).

[9] The challenge to the decisions of the GMC not to refer the allegations to a Tribunal are of direct consequence to Professor Ian Young and, therefore, he was joined as a notice party. Professor Young was not involved in Claire's clinical care but was asked by Dr Michael McBride, Medical Director, to review the records and advise as to whether hyponatremia and fluid balance could have played a part in Claire's death. Professor Young held joint appointments as an academic at Queen's University Belfast and as a clinician with the Royal Group of Hospitals Trust. He was a consultant in clinical biochemistry.

Order 53 Statement

[10] Mr Roberts challenges both the Rule 8 and Rule 12 decisions and seeks an order of certiorari quashing the impugned decisions; a declaration that the impugned decisions are ultra vires and an order of mandamus compelling the GMC to conduct a *de novo* investigation or alternatively a *de novo* reconsideration of the Rule 12 decision by an independent assistant registrar.

The grounds of challenge

[11] The grounds of challenge set out in the Order 53 statement, in summary are:

(a) Misapplication of the legal test for dishonesty.

(b) Failure to adhere to GMC policy.

(c) Failure to adjudicate upon specific allegations which was a material error.

(d) Failure to appreciate the fundamental factual conflict in the case.

(e) Failure to take into account relevant factors/taking into account irrelevant factors.

(f) *Wednesbury* unreasonableness.

(g) Failing to find any grounds for a formal review under Rule 12.

[12] At the hearing, Mr McQuitty helpfully refined the grounds of challenge as follows:

(a) Failure to adhere to GMC policy regarding the realistic prospects test.

(b) Misapplication of the legal test for dishonesty.

(c) Failure to adjudicate upon specific allegations of dishonesty which amounted to a material error.

[13] The central tenet of the applicant's challenge is that Professor Young believed at the time he conducted the review of Claire's notes and records in 2004, that there was clinical mismanagement because the treating doctors failed to carry out a repeat blood test on the morning of 22 October 1996 ("repeat blood test"). The applicant therefore contends that Professor Young was dishonest when he failed to disclose this and or gave misleading information when he met the parents on 7 December 2004 ("parents' meeting"); when he contributed to a letter sent to the parents on 12 January 2004 ("the letter"); and when he gave evidence to the inquest in 2006 ("the inquest").

[14] The mainstay of the applicant's criticism of the GMC decisions is that they failed to refer the case to the Tribunal in circumstances where, on the same materials, a public inquiry into the events surrounding and following the deaths of a number of children including Claire Roberts, made adverse findings against Professor Young which the applicant submits established a prima facie case of dishonesty. The applicant contends that this was not something the GMC could properly displace

and in doing so failed to adhere to GMC policy and/or acted irrationally; misapplied the test for dishonesty and failed to adjudicate upon specific allegations.

[15] Whilst the focus of the judicial review challenge is upon alleged failings and errors with the impugned decisions of the GMC, it is necessary to consider the background facts and the underlying evidential materials in some detail to understand and then analyse the applicant's criticisms of the GMC decisions.

Background

[16] On 21 October 1996, Claire Roberts ("Claire"), then aged nine, was admitted to the Royal Victoria Hospital for Sick Children with symptoms of vomiting, lethargy and slurred speech. The consultant in charge was Dr Steen. Claire was placed on an IV infusion and a blood test at midnight recorded serum sodium level just below the normal range.

[17] During the afternoon of 22 October 1996, Claire's condition deteriorated, and her level of consciousness reduced. Blood tests were not repeated on the morning of 22 October 1996. Blood tests were not taken until 21:30 hours that evening and the blood test results at 23:30 hours revealed that her serum sodium level had fallen to a dangerously low level. It is this failure to carry out a repeat blood test which is centrally relevant to the applicant's challenge.

[18] On 23 October, Claire suffered respiratory arrest and was transferred to paediatric ICU. A CT scan confirmed severe cerebral oedema and, sadly, life support was discontinued later that day because it was considered Claire could not survive given her brain injury.

[19] Claire's death was not referred to the coroner at that stage and the cause of death was certified as being "cerebral oedema secondary to status epilepticus." Hyponatremia was omitted from the certificate.

[20] On 21 October 2004, UTV broadcast a programme regarding the deaths of three children in similar circumstances to Claire's. Claire's parents then contacted the hospital to raise concerns.

[21] In November 2004, the Health Minister in Northern Ireland set up an inquiry into hyponatremia related deaths under the chairmanship of Mr O'Hara QC. The terms of reference were an inquiry into the care and treatment of the deceased children "with particular reference to the management of fluid balance; the actions of various organisations and individuals concerned in the procedures, investigations and events which followed the deaths and, information on explanations given to the respective families and others by the relevant authorities" ("the Inquiry").

[22] Hyponatremia refers to a condition in which the concentration of sodium in the blood falls below safe levels. If left untreated a significant fall in sodium

concentration may induce a cerebral oedema leading to swelling of the brain stem, respiratory arrest and death. Symptoms of hyponatremia are often lethargy, headaches, nausea and vomiting. A diagnosis can be made straightforwardly by testing the levels of sodium in the blood. Dilution hyponatremia should not happen in a hospital because such a patient will be the subject of active fluid therapy or management. Accordingly, it is a preventable hospital illness.

[23] On 6 December 2004, Professor Young on foot of a request from Dr McBride, reviewed Claire's records to determine whether hyponatremia and fluid balance could have played a part in Claire's death.

[24] Upon review of the notes, Professor Young advised Dr McBride that hyponatremia may have made a significant contribution to Claire's death.

[25] On 6 December 2004, Professor Young attended a meeting with Dr Steen where he shared his opinion. Dr Steen's view on fluid management was rather different to his and she only acknowledged, as a possibility, the relevance of hyponatremia. It was agreed that the coroner would be notified regarding Claire's death although this step was delayed until after a meeting with the parents, Mr and Mrs Roberts.

Parents' meeting – 7 December 2004

[26] On 7 December 2004, a meeting took place between Mr and Mrs Roberts, Dr Steen, Dr Rooney and Professor Young which was minuted. The minutes of this meeting record that Mr Roberts queried whether the administering of fluids had influenced Claire's condition. Professor Young joined in at this point emphasising that he was involved in the case purely as an independent advisor. He explained that hyponatremia may have contributed to Claire's death and stated that treatment today is very different as blood tests are taken more frequently, thereby speedily picking up any fall in sodium levels. The Professor added that it was not possible to say whether these new procedures would have helped Claire as she was so unwell. Mr Roberts then asked if Claire's sodium level had been monitored in between arriving at hospital and 24 hours later. Professor Young confirmed that it had not stating, "this was not unusual at that time. Treatment today, however, involves approximately six-hourly checks and the use of the CT scanner."

[27] Following this meeting, on 8 December 2004, Mr Roberts sent a letter to the hospital raising a series of questions. This included Question 2 which asked:

> "Claire's sodium was checked at 8pm on Monday 21st, reading 132mmol/l. Should this level have raised concerns and should it have been checked and monitored every one to two hours? Was this an early indication of hyponatraemia which is defined as a sodium level less than 135mmol/l?"

and Question 3 which asked:

> "… why was Claire's sodium level unchecked for 27 hours? How many blood tests were carried out on Tuesday 22nd?"

[28] On 17 December 2004, the hospital sent a letter to Mr and Mrs Roberts stating that Professor Young's review of Claire's medical care suggested, "that there may have been a care management problem in relation to hyponatremia and that this may have significantly contributed to her deterioration and death."

The letter – 12 January 2005

[29] On 12 January 2005, the hospital then responded to the questions raised in Mr Roberts' correspondence dated 8 December 2004. It is common case that there were several drafts of this letter, and that Professor Young contributed to the letter although it is disputed in what way. The letter was signed by Dr Rooney. The response to Question 2 was in the following terms:

> "While Claire's sodium level was slightly low when it was recorded as 132mmol/l on admission, this would not have been regarded as unusual in a child presenting with an illness similar to Claire's.
>
> Practice now would involve approximately six-hourly checks and use of the CT scanner. However, in 1996, before there was such extensive knowledge about hyponatremia, it would have been <u>normal practice to monitor sodium levels every 24 hours.</u>" (emphasis added)"

[30] In response to Question 3, it stated as follows:

> "… As already explained, <u>common practice in 1996 would have been to monitor sodium levels approximately every 24 hours.</u>
>
> One blood test with two samples was taken on 22 October. This was taken at approximately 9pm." [emphasis added]

The Inquest

[31] In May 2006, the coroner held an inquest into Claire's death. In the weeks leading up to the inquest, Professor Young was sent the deposition of Dr Webb by the Director of Litigation in the Trust.

[32] Dr Webb, Consultant Paediatric Neurologist, was one of the treating consultants. He saw Claire at 2pm on 22 October 1996. In his witness statement he stated as follows:

> "It would be routine for children on intravenous fluids to have their urea and electrolytes measured on a daily basis or more frequently if necessary … blood testing in hospital is routinely undertaken first thing in the morning and, I believe, I erroneously understood the … result report on Claire to have been that morning's result … I believe, that if I had understood the result to have been from the previous evening I would have requested an urgent repeat sample."

[33] Upon receipt of Dr Webb's statement, Professor Young emailed the Director of Litigation on 7 April 2006 stating as follows:

> "…
>
> This seems to me a clear statement that Dr Webb believes that hyponatremia played a significant part in Claire's death … Dr Webb also draws attention to the failure to take an electrolyte sample in the morning following Claire's admission, which he states was routine practice. In addition, he states that he believes at the time if such a sample had been taken and that if he had been aware that the sodium of 132 had been taken the previous evening that he would have requested an urgent repeat.
>
> These are substantial issues which were not fully discussed during our meeting this morning, and which could certainly become significant at the inquest."

[34] Dr Bingham, the coroner's independent expert, gave evidence to the inquest regarding the general frequency of blood testing in 1996. He said:

> "In practice blood tests every 24 hours do not happen in relation to patients on intravenous fluids. It is difficult to take blood samples from children – in Great Ormond

> Street it is taken from 1/3 children. Blood samples and urine samples should be taken every 24 hours."

[35] Professor Young made two depositions to the inquest. The first was a witness statement dated 25 April 2006, in which he stated that following the request by Dr McBride to review the case notes, he formed the view that hyponatremia may have made a contribution to Claire's death, and he had advised Dr McBride accordingly. Professor Young also gave oral evidence at the inquest. He was asked several questions by Mr McCrea, counsel for the coroner, and his responses were recorded by the coroner in a handwritten note. This handwritten note was then signed by Professor Young and constituted his second deposition to the inquest. The second deposition states:

> "A blood sample every 24 hours would be good clinical practice."

[36] There is no transcript of the evidence given by Professor Young to the coroner. The solicitors for the Trust, Brangham & Bagnall made detailed notes of Professor Young's evidence and these notes record the following questions and answers:

> "Mr McCrea: Good clinical practice to take blood first thing in the morning?
>
> Prof Young: At least once a day, usually taken in children hospital in afternoon.
>
> Mr McCrea: Should blood have been taken that morning?
>
> Mr Lavery (counsel for the Trust) objects to this line of questioning."

[37] As appears from these notes, Professor Young did not answer the question posed by Mr McCrea regarding whether blood should have been taken that morning and Mr McCrea then moved on to ask questions about other issues.

The Inquiry

[38] The inquiry obtained several statements from various witnesses including the parents, treating clinicians and Professor Young. In total, Professor Young provided six statements to the Inquiry.

Professor Young's first statement to the Inquiry

[39] His first statement dated 14 September 2012 was made in response to questions raised by the Inquiry. In response to the Inquiry's question:

> "In respect of your review of the case notes of Claire Roberts, did you form any other views in respect of shortcomings or deficiencies you may have noted in the following areas …"

Professor Young responded as follows:

> "As indicated above, the purpose of my review was to determine whether hyponatremia may have contributed to Claire's death and not to reach any conclusions about the possible shortcomings or deficiencies in her care. Therefore, I did not fully consider all aspects of the quality of care which was provided. However, I did form views about some aspects of her care during my review of the case and I refer to these below…
>
> (iii) The record of fluid balance and management; choice and rate of admission of fluids to Claire was in line with common practice at the time of her admission, though not in line with practice at the time of my review. There was an accurate record of fluid intake but not of fluid output. The monitoring of serum electrolytes *(ie blood testing)* did not occur with sufficient frequency given the severity of Claire's medical condition. Once severe hyponatremia was identified, management of fluid balance was appropriate but Claire may already have suffered significant adverse consequences as a result of this." (underlining added)

Professor Young's oral evidence to the Inquiry

[40] During his oral evidence to the Inquiry Professor Young was questioned about receipt of the statement from Dr Webb prior to the 2006 inquest. The transcript records the following exchange between the Chairman and Professor Young:

> "Chairman: …Dr Webb believes that hyponatraemia played a significant part in Claire's death… He is closer to your line of thinking than Dr Steen was in terms of emphasis?

Young: Absolutely, at that point. And I hadn't, I think, been aware of that before, which was why I was highlighting it because I thought …Dr Webb, did seem to me, to be closer to my position …

Chairman: …Then the paragraph that you did take me to a moment ago, when it really draws attention to the failure to take a sample in the morning, that's an indication that Dr Webb has realised that he has misunderstood the notes because his evidence during the inquiry was that, when he saw the notes, he thought the sample had been taken that morning.

Young: Absolutely, and I think that indicates, before the coroner's inquest, that Dr Webb's position certainly was that he had misunderstood the timing of the sample. Otherwise, he would have requested another one urgently.

Chairman: And you agree with him on that?

Young: That there should have been? Absolutely, yes.

Chairman: So the sample which was taken on Claire's admission the previous evening should have been updated on the Tuesday morning?

Young: I think I should have said to yourself before, and I agree completely, if that had happened, very probably this all could have been avoided … in terms of the hyponatremia contribution at least.

Chairman: We will never know, but there is a very good chance it would have shown some reduction in the sodium level?

Young: I'm pretty certain."

[41] The Inquiry heard evidence from several treating clinicians, including Dr Volpracht, Dr Sands, Dr Webb and Dr Steen. All the doctors, including Dr Steen, when they gave evidence to the Inquiry, agreed that a repeat blood test should have been carried out in Claire's case and that a failure to do so represented a failure in Claire's medical care.

Professor Young's last statement to the Inquiry

[42] Professor Young was present at the Inquiry when Dr Steen gave evidence. Following this, and in response to her evidence, he filed his sixth and final witness statement on 7 January 2013. This witness statement stated as follows:

> "The purpose of this statement is to respond to several issues which arose in evidence following my appearance at the inquiry …
>
> During her oral evidence on Day 71, Dr Steen suggests that in 2004 during the meeting with Claire's parents, she came to the view that there had been fluid mismanagement in 1996. I was very surprised at that statement. In 2004, Dr Steen did not indicate to me or in any meeting that I attended that she believed that fluid mismanagement had occurred in 1996 when judged by the standards prevailing at that time. The first time that I heard her express this view was in oral evidence to the inquiry on 18 December. This was not a view which I shared or was aware of in 2004 … A related issue was the frequency of blood sampling. In 2004, I believed that the prevailing standard in 1996 was to check electrolytes once every 24 hours in a child on intravenous fluids – therefore I did not believe that the failure to check bloods during the day constituted mismanagement, though it was clear that it would have been better if this had been done … My position on this was reinforced by comments made by the coroner's expert witness Dr Bingham at the inquest …' in practice blood tests every 24 hours do not happen in relation to patients on intravenous fluids … blood samples and urine samples should be taken every 24 hours.'
>
> Having subsequently heard this issue discussed at length by a number of expert witnesses and the medical staff involved in Claire's care in the context of the current inquiry, I accept that in Claire's case in 1996 a blood sample should have been taken during the day on Tuesday. However, in 2004 I did not believe that the

> failure to do this constituted fluid mismanagement by 1996 standards and at no stage did Dr Steen suggest this to me … In summary I want the inquiry to be entirely clear that I did not believe in 2004 that there had been fluid mismanagement by 1996 standards in Claire's case and that I was not aware of Dr Steen holding such a view at that time … The information which I provided to Claire's parents and to the inquest was entirely in line with these views which I have expressed throughout my involvement and evidence from 2004 to the present and have justified from my analysis of the clinical records and contemporary medical literature."

[43] This statement was received by the Inquiry before it published its report. The chairman commented upon the fact the statement was unsolicited and that it criticised Dr Steen. This statement was not however expressly referenced in the final report when the Inquiry made adverse findings about Professor Young's knowledge regarding repeat blood testing.

Key findings of the Inquiry regarding Professor Young

[44] The Inquiry published its report in January 2018. It made several adverse findings in respect of Professor Young. It is accepted there was no "Maxwellisation" process prior to the publication of these findings whereby Professor Young could respond to the criticisms.

[45] At para 3.260 the Inquiry report records that prior to the parents' meeting on 7 December 2004 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."

The Inquiry, therefore, made a finding that Professor Young had formed the belief in 2004 that the failure to carry out a repeat blood test on the morning of 22 October 1996 represented clinical mismanagement in Claire's clinical care.

[46] The Inquiry records the basis for this conclusion in its foot notes. These reference the portion of Professor Young's first statement to the Inquiry set out at para [39] above and the transcript of Professor Young's evidence to the Inquiry set out at para [40] above and records at para 3.276, after referring to Dr Webb's evidence that he would have directed an urgent repeat blood test:

> "Professor Young agreed that this is indeed what should have been done."

[47] Having found that Professor Young held this belief in 2004 the Inquiry then made several adverse comments about Professor Young's conduct, specifically what was said and not said, at the parents' meeting, in the letter and at the 2006 inquest.

[48] In relation to the parents' meeting, the Inquiry reported at para 3.260 as follows:

> "…My main concern about the meeting is…that there was no acknowledgment at the meeting that Claire should have had a repeat blood test on the morning of the 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.'"

[49] In respect of the letter, the Inquiry reported at para 3.264 and 3.265 as follows:

> "3.264 Unfortunately, some of the content is highly questionable:
>
> (i) …
> (ii) …
> (iii) …
>
> (iv) It ignores other matters completely …
>
> 3.265 The letter was inaccurate, evasive and unreliable."

[50] In respect of the 2006 inquest, the Inquiry reported as follows:

> "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 …
>
> 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.'
>
> (This was a reference to the second deposition of Professor Young set out at paragraph [35] above.)
>
> 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.
> …
>
> 3.280 In 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."

Events post publication of the Inquiry report

[51] Following the publication of the Inquiry report, Professor Young referred himself to the GMC. On 23 March 2018 Mr Roberts also submitted a complaint to the GMC regarding Professor Young's fitness to practice.

[52] The GMC identified three allegations against Professor Young, all based upon the findings in the Inquiry report.

[53] On 14 November 2018, the assistant registrar of the GMC decided the allegations against Professor Young should not proceed any further by virtue of the "five year" rule.

[54] Mr Roberts sought a review of that decision under Rule 12. On 9 January 2020, a different assistant registrar decided that the 14 November 2018 decision was materially flawed and substituted a fresh decision that the allegations should proceed.

[55] Professor Young judicially reviewed the 9 January 2020 decision and on 9 March 2021, Holgate J rejected his application. The decision is reported as *R(On the application of Professor Ian Young) v GMC* [2021] EWHC 534 (Admin).

[56] After the GMC decided to refer the case to the case examiners, in accordance with Rule 4, the registrar conducted an investigation into the allegations and gathered relevant evidence.

[57] This investigation generated a large volume of materials which included the following:

(a) Witness statements made to the GMC by Mr and Mrs Roberts, Dr McBride, Mr Leckey (Coroner), Dr Rooney, Dr Burton and a supplementary statement by Mr Roberts.

(b) Exhibits to these witness statements included:

  (i) a transcript of Mr and Mrs Roberts' evidence to the Inquiry;

  (ii) Mr Roberts' statement to the inquest;

  (iii) expert reports and clinician notes;

  (iv) the coroner's inquest documents which included witness statements, expert reports, solicitors' notes of the hearing and other information from the Trust;

  (v) Minutes of the meeting with the parents on 7 December 2004;

  (vi) Iterations of the letter sent to the parents on 12 January 2005.

(c) Witness statements made to the Inquiry, including all Professor Young's witness statements.

(d) Transcript of the evidence given at the Inquiry.

(e) The Inquiry report

(f) Further correspondence to the GMC.

[58] After concluding its investigation the registrar then wrote to Professor Young on 14 March 2002, enclosing the draft particulars of allegations and all the materials gathered during the GMC investigation, inviting him to provide comments for consideration by the GMC.

The allegations

[59] The GMC investigation and the allegations against Professor Young centred on concerns that he knew/believed that failure to carry out repeat blood tests on the morning of 22 October 1996 amounted to clinical mismanagement in Claire's case

and notwithstanding this knowledge or belief he failed to acknowledge this failing and or otherwise gave misleading information at the parents' meeting, in the letter and at the 2006 inquest.

[60] The draft particulars of allegations provided to Professor Young set out in 10 paragraphs details of the alleged misconduct which rendered him unfit to practise. Mr McQuitty accepted that the relevant allegations for the purpose of this judicial review are as follows:

> "1. On 7 December 2004, during a meeting with Patient A's parents, at the Royal Belfast Hospital Trust ("the Trust") you:
>
> (a) failed to accurately disclose that:
>
> (i) a repeat blood test should have been undertaken:
>
> (1) on the morning of 22 October 1996;
>
> (2) more frequently given the severity of Patient A's condition;
>
> (ii) the drop in sodium level to 121mmol/l was related to fluid and electrolyte mismanagement from not repeating the blood test;
>
> (b) falsely claimed:
>
> (i) that Patient A was so unwell that it was not possible to say whether a frequent blood test would have helped her …
>
> 2. Your communications with ... parents as described in paragraph 1 above were dishonest in that you knew:
> …
>
> (d) the monitoring of a serum electrolytes did not occur with sufficient frequency given the severity of Patient A's clinical condition.
>
> 3. On 12 January 2005 your contribution to the production of a draft letter ("the letter") for Patient A's parents was inappropriate in that you…

(b) falsely confirmed:

…

(ii) that in 1996, it would have been normal practice to monitor the sodium level every 24 hours;

…

(c) knew:

(iii) the letter contained inaccuracies as described in paragraph 3(b) above, but you did not correct them in the letter;

the mistakes described in paragraph 1(a) had been made and you failed to provide this information in the letter;

…

5. On 5 May 2005, you provided an inaccurate statement for the Coroner's inquest into Patient A's death, in that you failed to disclose the matters described in paragraph 1 …

6. On 4 May 2006, you provided inaccurate evidence during the coroner's inquest in that you:

(a) failed to disclose the matters described in paragraph 1 …

(b) stated a blood sample every 24 hours would be good clinical practice …"

Professor Young's statement in response to the GMC

[61] On 14 June 2022, Professor Young provided a detailed response to the GMC which included exhibited materials. Under "Background" the statement stated:

"2. Professor Young first became involved in Claire's case in 2004 when he was requested by…Dr McBride to review Claire's records and advise whether hyponatremia and fluid balance may have made a contribution to Claire's death...

5. The purpose of the review was to advise whether hyponatremia may have contributed to her death and not to reach any conclusions about possible shortcomings or deficiencies in her care. Professor Young concluded that

hyponatremia may have played a role, conveyed this information to Dr McBride and recommended that the death should be referred to the coroner…

6. Professor Young did not therefore fully consider all aspects of the quality of care that was provided…He did however form views about some aspects of Claire's care during his review of the case, including in respect of the record of fluid balance and management."

[62] In relation to the central issue concerning his state of knowledge about whether the failure to carry out repeat blood tests on the morning of 22 October 1996 constituted mismanagement the following extracts of the statement are of relevance:

"7. Professor Young was of the view that Claire's fluid management was not in keeping with prevailing standards of 2004…In 2004 Professor Young believed that the prevailing standard in 1996 was to check electrolytes once every 24 hours in a child on intravenous fluids …

9. Professor Young did not therefore believe in 2004 that the failure to check bloods during the day on 22 October 1996…constituted mismanagement by the prevailing standards in 1996…Professor Young recognised that the management of fluid and electrolyte balance in Claire's case did not meet the standards of 2004, which had changed substantially from those of 1996…and sought to explain this in the meeting with Claire's parents in 2004…

10. Professor Young's view in relation to the general frequency of blood sampling in 1996 was subsequently supported by the expert evidence of Dr Bingham…at the inquest in 2006…

…

Allegation 1: On 7 December during a meeting with Claire's parents you failed to accurately disclose that a repeat blood test should have been undertaken on the morning of 22 October 1996 given the severity of her condition

…

15. …Professor Young did not disclose at the meeting that a repeat blood test should have been undertaken…It is not however accepted that Professor Young's actions in doing so were a failure. In 2004, Professor Young was

> not of this view (ie that a repeat blood test should have been undertaken on the morning of 22 October 1996) and therefore did not disclose and would not have disclosed this to Claire's parents …
>
> 20. Professor Young first became aware of the view that the initial blood sample should have been repeated…when he saw the deposition of Dr Webb on 7 April 2006. Professor Young agreed in a written submission prior to the inquest and verbally at the inquest with the views of the coroner's independent expert Dr Bingham on this point and was prevented at the inquest from answering questions on it by legal intervention upheld by the Coroner.
> …
>
> *Allegation 2: …Professor Young knew "the monitoring of serum electrolytes did not occur with sufficient frequency given the severity of Patient A's clinical condition.*
> …
>
> 65. Professor Young accepts there was a lack of clarity in respect of the above statement which was made by him in response to a query by the Inquiry in 2012, in that he did not specify to what standards he was referring in his response and was not asked to clarify. This was Professor Young's view based on having read the opinions of a range of paediatric experts at that time. In 2004 Professor Young believed that the monitoring of serum electrolytes did not occur with sufficient frequency by the standards of 2004 and sought to explain this to Claire's parents in the 2004 meeting. In 2004, Professor Young believed that the prevailing standard in 1996 was to check electrolytes once every 24 hours in a child on intravenous fluids…"

GMC proceedings

[63] On 14 March 2023, the case examiners decided to take no further action against Professor Young – the Rule 8 decision.

[64] On 24 April 2023, Mr Roberts sought a review of that decision. On 10 August 2023, the assistant registrar refused the request for a review – the Rule 12 decision.

[65] On 6 November 2023, Mr Roberts issued the instant judicial review proceedings.

Relevant legal and regulatory framework

[66] The 2004 Rules provide for the investigation and adjudication of complaints in respect of a doctor's fitness to practise. Complaints are investigated under Rule 7 and provided the criteria are met, they are then referred by the registrar to the case examiners for consideration.

[67] In accordance with Rule 8(2):

> "Upon consideration of an allegation the case examiners may unanimously decide –
>
> (a) That the allegation shall not proceed further; …
>
> (d) refer the allegation to the Medical Practitioners Tribunal Service for them to arrange for determination by a Medical Practitioners Tribunal."

[68] Under Rule 8(4):

> "As soon as reasonably practicable, the case examiners shall inform the registrar of their decision, together with the reasons for that decision and the registrar shall notify the practitioner and the maker of the allegation (if any), in writing, accordingly."

[69] Rule 12 provides for the review of certain decisions, including a decision not to refer an allegation to a Tribunal. Rule 12(2) provides:

> "The registrar may review all or part of the decision…when the registrar has reason to believe that:
>
> (a) the decision may be <u>materially flawed</u> (for any reason) wholly or partly … 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."

[70] Rule 12(7) provides:

> "(7) Where the Registrar has reviewed all or part of a decision specified in paragraph (1), he shall notify -
> …
>
> (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."

Relevant GMC guidance

Realistic prospects tests

[71] The GMC guidance "Making decisions on cases at the end of the investigation stage: Guidance for the Investigation Committee and Case Examiners" provides at para 14 as follows:

> "The case examiners will apply the following test at the conclusion of the investigation stage:
>
> The Investigation Committee or case examiner must have in mind the GMC's duty to protect the public which includes promoting and maintaining the health, and safety and well-being of the public; public confidence in the profession; and, proper standards and conduct for doctors, in considering whether there is a realistic prospect of establishing that a doctor's fitness to practise is impaired to a degree justifying action on registration."

[72] Annex B of this document sets out guidance in respect of the realistic prospects test. It states as follows:

> "1. The 'realistic prospect' test will apply to both the factual allegations and the question whether, if established, the facts would demonstrate that the practitioner's fitness to practise is impaired to a degree justifying action on registration. It will reflect a genuine (not remote or fanciful) possibility…

2. In performing their task, the case examiners and members of the Investigation Committee:

(a) should bear in mind that the medical practitioners tribunal is required to be persuaded that the facts are more likely than not to be true;…

(b) are entitled to assess the weight of the evidence;

(c) should not, however, normally seek to resolve substantial conflicts of evidence;

(d) should proceed with caution (given that, among other considerations, the case examiners are working from documents alone and the evidence before them may be untested);

(e) should proceed with particular caution in reaching a decision to halt a complaint where the decision may be perceived as inconsistent with a decision made by another public body with medical personnel or input (for instance, an NHS body, a Coroner or an Ombudsman) in relation to the same or substantially the same facts and, if the case examiners/Investigation Committee does not reach such a decision, should give reasons for any apparent inconsistency;…

(g) if in doubt, should consider whether any further investigation is appropriate and in any event should lean in favour of allowing the complaint to proceed to a medical practitioners tribunal;

(h) should bear in mind that whilst there is a public interest in medical practitioners not being harassed by unfounded complaints, there is also a public interest in the ventilation before a medical practitioners tribunal in public of complaints which do have a realistic prospect of establishing impaired fitness to practise;…"

[73] The GMC, "Rule 12 Frequently Asked Questions" document states as follows:

"What is the realistic prospects test?

> At the end of an investigation, the role of the case examiners is to decide whether there is a realistic prospect of proving, on the balance of probabilities, that the doctor's fitness to practice is currently impaired."

Rules and Guidance re reasons

[74] Para 124 of the GMC guidance "Making decisions on cases at the end of the investigation: Guidance for the Investigation Committee and case examiners" provides:

> "**Recording Decisions**
>
> 124. Decisions agreed by case examiners must be recorded on the file. All parties should be able to understand why a decision has been taken, even if they do not agree with the decision. Decisions should be recorded using the Case Examiner Decision Form. It is important that case examiners provide a detailed record of the reasons for their decisions."

GMC guidance on Rule 12 review

[75] Rule 12 provides that a registrar can review part or all of a decision if he has reason to believe that the decision may be "materially flawed" wholly or partly. The term "materially flawed" is not defined in the 2004 Rules. The GMC guidance "Rule 12 – FAQs" gives some guidance as follows:

> "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 lead to a different conclusion."

[76] It then gives examples which include factual errors or a failure to consider all allegations.

GMC decisions

Summary of Rule 8 decision

[77] The case examiners consisted of a practising medical doctor and a lay person. They had all the materials generated by the GMC investigation before them. After consideration of these materials, they decided not to refer the case to the Tribunal.

[78] The case examiners' reasoning is set out in a 40-page written decision dated 14 March 2023. After setting out the background; the concerns raised by Mr Roberts;

the adverse findings made by the Inquiry; and the materials generated by the GMC investigation, the case examiners' state:

> "A great deal of information has been provided to the GMC…the information received by the GMC is not all rehearsed in detail within this decision, but the documents have been considered in full and information that may be considered relevant with specific concerns raised about Professor Young is set out below."

[79] The case examiners separated the specific concerns raised into three areas: the 2004 meeting, the letter and the 2006 inquest. In respect of each of these three areas, the case examiners rehearsed in detail the adverse findings made by the Inquiry and summarised the evidence available to them making detailed reference to various witness statements and to the other materials generated by the GMC investigation including minutes, correspondence/emails, iterations of the 2005 letter, solicitors' notes of the evidence given at the inquest, Inquiry transcripts etc.

[80] After rehearsing all the allegations in full and after setting out a summary of Professor Young's response to the GMC, the case examiners, under the heading "Reasons for our decision" set out the test to be applied as follows:

> "As case examiners we must decide whether there is a realistic prospect of establishing that a doctor's fitness to practice is currently impaired to a degree justifying action on his or her registration (their right to practice).
>
> This test has two parts:
>
> - We must decide if the allegations are serious enough to warrant action on the doctor's registration.
>
> - We must also consider whether the allegations are capable of proof to the required standard, namely that is more likely than not that the alleged events occurred."

[81] Thereafter the case examiners referenced the relevant GMC guidance and set out the test for dishonesty as follows:

> "When considering dishonesty allegations, case law has suggested that we must consider:
>
> - Subjectively, the doctor's knowledge or genuine beliefs as to the relevant facts; and

- In light of the doctor's knowledge or belief, whether the doctor's conduct was objectively dishonest by the standards of ordinary decent people."

[82] The "decision reasoning" section then deals with each of the three areas identified. In respect of the parents' meeting on 7 December 2004, the case examiners summarised the allegations, set out their findings and then concluded as follows:

> "While we do acknowledge that the evidence indicates that Professor Young did not mention, for example, that another blood test should have been undertaken in 1996, the evidence does clarify that Dr Steen was discussing Claire's clinical care. The evidence before us indicates that Professor Young joined in/contributed at the meeting when issues of fluid management were raised (which was his area of expertise) and that it was Dr Steen who was intended to and did discuss Claire's clinical journey … We have not had any evidence put before us to suggest that Professor Young's role at that time would have required him or extended to commenting on the specifics of the 1996 failures in Claire's care, and we agree that with the limited information available about the instructions provided to Professor Young ahead of that meeting, it would be very difficult to draw this conclusion. We have therefore reached a view that there is insufficient evidence to substantiate any criticism of Professor Young in this regard (or things that he did not say at this meeting) …
>
> In conclusion, while it might factually be the case that Professor Young did not disclose certain matters to the family or made various comments during the meeting in question, overall, we conclude that there is insufficient evidence of dishonesty or evidence to suggest that Professor Young failed in his role at that meeting. In the absence of any dishonesty or cogent evidence of possible failings in his role as an expert/advisor, we agree, that these concerns do not meet the realistic prospect test and can be closed."

[83] In respect of the letter, the case examiners summarised the allegations, made various findings by reference to the evidence and concluded:

> "In the absence of evidence that Professor Young has made amendments to this letter which he categorically

> knew were false (rather than them being his opinion at the time which may have been wrong or later subject to change) we do not consider there is sufficient evidence before us to suggest that his contribution to this letter was dishonest."

[84] In respect of the coroner's inquest the case examiners referenced the allegations and after setting out in full the adverse findings of the Inquiry, stated:

> "In light of the Inquiry's comments, we have very carefully looked at the available evidence. In reaching our decision in respect of the concerns set out at the relevant paragraphs of the formal allegation we take into account that Professor Young had reached his initial opinion on fluid management in 2004 (in preparation for the meeting with Claire's parents) and the inquest took place in 2006. It is inevitable that during the two year intervening period Professor Young would have learnt more about Claire's care and during the course of the inquest (and thereafter up to the point of the inquiry) would have been subject to additional views and opinions. We must therefore accept that many comments made by Professor Young … should be considered to have been made with the benefit of additional information and hindsight. This may also mean that comments made by Professor Young changed over time."

[85] In relation to the evidence given by Professor Young at the Inquest, the case examiners noted the absence of a formal transcript and acknowledged that questions in this setting can often be nuanced and concluded as follows:

> "Without an exact transcript of questions and answers, we agree, that it is very difficult to evidence dishonesty (particularly dishonesty by omission) on the part of Professor Young unless that dishonesty is clear and unambiguous…We have not been provided with any cogent evidence that when Professor Young was asked a specific question by the Coroner he responded with an answer which he knew was wrong…While acknowledging the criticisms raised by the inquiry in respect of Professor Young, we do not consider that based on the entirety of the evidence in this case and specifically that related to the inquest that there is sufficient evidence to conclude that the information he presented at the inquest was either clinically seriously substandard or dishonest."

[86] In the "final comments" section, the case examiners recognised the particular concern raised in the case related to the question of whether Claire should have had a repeat blood test. They concluded that:

> "The evidence before us indicates that Professor Young …did not consider the actions taken in 1996 to have been out of keeping with the usual practise at that time…"

Rule 12 decision

[87] In a written decision dated 10 August 2023, the assistant registrar concluded that there were no grounds for commencing a review of the case examiners' decision. After setting out the background and details of the documents and evidence considered the assistant registrar correctly set out the test for review under Rule 12. The assistant registrar considered each point made in Mr Roberts' request for a review and concluded at paras 20 and 21 as follows:

> "20. Notwithstanding some potential inaccuracies, the remaining questions and some evidence that is open to interpretation, I have reached the conclusion that I agree there is no evidence which meets the standard of proof for a realistic prospect of demonstrating to a tribunal that Professor Young has been dishonest…
>
> 21. …It is my view that nothing less than strong evidence of dishonesty, with a view to cover up, would justify a referral to the medical practitioners tribunal. This reasoning is, in my view, reflected in the case examiners extensive consideration of the evidence."

Questions for determination by the court

[88] I consider the following questions arise for determination:

(i) Is the challenge out of time and, if so, should time be extended?

(ii) Did the case examiners fail to adhere to GMC policy regarding the realistic prospects test and or otherwise act irrationally?

(iii) Did the GMC examiners misapply the legal test of dishonesty?

(iv) Did the case examiners make a material error in failing to consider each individual allegation of dishonesty?

Question 1 – Is the Rule 8 challenge out of time?

[89] Under Order 53 rule 4 of the Rules of the Court of Judicature, an application is required to be brought "within three months from the date when grounds for the application first arose unless the court considers that there is good reason for extending the period within which the application shall be made."

[90] Under the 2004 Rules, a party can seek a review of a Rule 8 decision not to refer an allegation to the Tribunal. Under Rule 12(2) the registrar may review all or part of the decision when the registrar has reason to believe that "the decision may be materially flawed for any reason."

[91] The Rule 8 decision was made on 14 March 2023. Mr Roberts sought a review of that decision. The Rule 12 decision was then made by the assistant registrar on 10 August 2023, and this was communicated to Mr Roberts on 15 August 2023.

[92] The GMC submits that the challenge to the Rule 8 decision is now out of time. Mr McAteer accepts that the Rule 12 challenge is within time and that this challenge will require a detailed consideration of the Rule 8 decision given that the test upon review is whether the Rule 8 decision is "materially flawed." Nonetheless, he submitted that the focus should be on the Rule 12 decision and the court should refuse leave to judicially review the Rule 8 decision on the ground it is time barred.

[93] I consider that Mr Roberts' delay in seeking judicial review of the Rule 8 decision was because Mr Roberts was exercising his rights under the statutory scheme to seek a review of the Rule 8 decision. If Mr Roberts had brought a judicial review of the Rule 8 decision at the time it was promulgated, it would probably have been considered premature.

[94] The primary challenge to the Rule 12 decision is that the assistant registrar failed to identify "material flaws" in the Rule 8 decision. The Rule 8 decision therefore is the primary impugned decision as any challenge to the Rule 12 decision of necessity requires detailed consideration of the Rule 8 decision to determine if it is "materially flawed."

[95] In the circumstances, I extend time to permit judicial review in respect of the Rule 8 decision. Accordingly, the court will consider the challenge to both the Rule 8 and the Rule 12 decisions.

Question 2 – Was there a failure to adhere to GMC policy regarding the realistic prospects test?

Applicant's submissions

[96] Mr McQuitty submitted that the case examiners, in deciding not to refer the case to the Tribunal acted in breach of GMC guidance in respect of the realistic prospects test, as they:

(a) Failed to exercise "particular caution", contrary to the GMC guidance set out at para 2(e) Annex B, in deciding that there was no or insufficient evidence of dishonesty to refer the case to the Tribunal when that decision may be perceived as inconsistent with the findings made by the Inquiry

(b) Resolved conflicts of evidence, contrary to para 2(c) of the Annex B guidance; and

(c) Contrary to Rule 8(4) of the 2004 Rules and para 120 of the GMC guidance, failed to give cogent and compelling reasons explaining how they resolved the criticisms made of Professor Young by the Inquiry so as to reach a conclusion that there was no or insufficient evidence of dishonesty to refer the case to the Tribunal.

Relevant legal principles for judicial review

[97] The proposed applicant is applying for leave to seek judicial review against the decisions of the case examiners and the assistant registrar. In such an application the court is only concerned with the legality of the decision making and not with the merits of the decision – see *Tesco Stores Ltd v Secretary of State for the Environment* [1995] 1 WLR 759 at 780H.

[98] In *Bloor Homes East Midlands Ltd v Secretary of State for Communities and Local Government* [2014] EWHC 754, Lindbloom J provided a useful summary of the general principles governing judicial review in this type of case. Although it was a planning case, the principles enunciated have been read across to apply in other judicial review challenges where the focus is on the exercise of discretion by a statutory decision maker: see *KE* [2016] NIQB 9 at para [52] and *DoE v Cunnigham* [2006] NICA 12 at para [68].

[99] In summary the seven principles enunciated by Lindbloom J are:

(a) Decisions are to be construed in a reasonably flexible way and need not rehearse every argument relating to each matter in every paragraph as the decisions are written for parties who know the issues between them and the evidence and the arguments deployed.

(b) The reasons must be intelligible and adequate enabling the reader to understand why the appeal was decided as it was and what conclusions were reached on the principal important controversial issues.

(c) The weight to be attached to any material consideration is within the exclusive jurisdiction of the decision-maker provided it does not lapse into *Wednesbury* irrationality.

(d) The interpretation of policy is a matter of law for the court. The application of relevant policy is for the decision maker.

(e) When it is suggested a decision-maker failed to grasp a policy, the court must decide whether it appears from the way the decision-maker dealt with the issues, he must have misunderstood the policy.

(f) The fact a particular policy is not mentioned in the decision does not necessarily mean it has been ignored.

(g) Whilst consistency is to be desired it is not a principle of law that like cases must always be decided alike.

[100] As was noted Holgate J at para [70] when considering Professor Young's judicial review challenge to the decision of the assistant registrar:

> "Plainly the court is reviewing the judgments reached by the Assistant Registrar. It is not determining the issues before the Registrar for itself and may not substitute its own view. It may only intervene if the Assistant Registrar 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 decision should be read fairly and as a whole.**"

[101] Mr McQuitty did not raise any issues regarding the case examiners' interpretation of the GMC guidance. Rather, his complaint was about their application of the guidance. As *Bloor Homes* states, the application of relevant policy is for the decision-maker and the weight to be attached to any material consideration is within the exclusive jurisdiction of the decision maker subject to *Wednesbury* irrationality. Mr McQuitty conceded that the applicant's criticisms chiefly involved a challenge to the exercise of judgment by the case examiners.

[102] The central tenet of Mr Roberts' challenge was that the case examiners' decision not to refer the case to a tribunal on the grounds there was no or insufficient evidence of dishonesty, was irrational because:

(a) The available evidence demonstrated that Professor Young in 2004 knew or believed the failure to carry out a repeat blood test was clinical mismanagement in Claire's case and notwithstanding this knowledge he failed to disclose this information or otherwise provided misleading information at the parents' meeting, in the letter and at the 2006 inquest.

(b) The Inquiry made adverse findings against Professor Young which established a prima facie case of dishonesty, and these findings could not rationally be displaced as they were made on the same evidential materials.

(c) The case examiners took into account irrelevant factors and failed to take into account relevant factors.

Was the case examiners' decision irrational in light of the evidence?

Parties' submissions

[103] The parties agreed that the critical issue underlying all the allegations of dishonesty was the question whether Professor Young believed in 2004 that the failure to carry out repeat blood tests in Claire's case amounted to clinical mismanagement.

[104] The case examiners concluded that there was no or insufficient evidence establishing that he held this belief in 2004 and accordingly found the realistic prospects test was not met and therefore did not refer the case to the Tribunal.

[105] Mr McQuitty submitted that the case examiners' decision was irrational as the evidence unequivocally demonstrated that Professor Young knew or believed in 2004 that the failure to carry out repeat blood testing on the morning of 22 October 1996 amounted to clinical mismanagement in Claire's case. Accordingly, he was dishonest when he failed to disclose this to the parents and otherwise misled them at the parents' meeting, in the letter and when he gave evidence at the 2006 inquest.

[106] In support of this contention Mr McQuitty relied on Professor Young's first statement to the Inquiry when he stated:

> "I did form views about some aspects of her care during my review…The monitoring of serum, electrolytes (ie blood testing) did not occur with sufficient frequency given the severity of Claire's medical condition…"

Mr McQuitty submitted Professor Young thereby accepted when he carried out his review in 2004, he formed the view that blood testing did not occur with sufficient frequency given the severity of Claire's condition.

[107] Further, when he gave oral evidence to the Inquiry, in response to a question by the Chairman regarding Dr Webb's view that repeat blood tests ought to have been done, Professor Young replied, "absolutely, yes."

[108] Mr McQuitty submitted that Professor Young's reference to evolving standards in his response statement to the GMC investigation was a "red herring" as he had stated in his first statement to the Inquiry that repeat blood tests were needed because of Claire's condition as opposed to the standards prevailing at that time.

[109] Finally, Mr McQuitty submitted that the unanimous evidence of the treating clinicians to the Inquiry (that failure to carry out repeat blood tests represented mismanagement in Claire's case), fortified the conclusion that Professor Young, an experienced expert, did believe in 2004 that the failure to carry out repeat blood tests represented mismanagement in Claire's case.

[110] In contrast, Mr McGleenan on behalf of the notice party, submitted that Mr McQuitty's reference to the evidence was partial and partisan and his interpretation of Professor Young's first statement and oral evidence to the Inquiry was confounded by the other material evidence.

[111] Firstly, he submitted that there were indicators within the first statement which showed it should not be interpreted in the way Mr McQuitty advocated. Specifically, it did not state the date Professor Young was referring to and Professor Young in his response to the GMC allegations accepted there was a lack of clarity in his first statement to the Inquiry as he did not state his view had been reached with the benefit of hindsight. When Professor Young made his final statement to the Inquiry, after hearing the *volte face* in Dr Steen's evidence about the failure to carry out repeat blood tests he explained he did not hold this view in 2004 and that his views had evolved over time.

[112] Secondly, Mr McGleenan submitted that the other material evidence confounded the interpretation contended for by Mr McQuitty. This material disclosed that when Professor Young met the parents in 2004, he had access only to Claire's notes and records and had only met Dr Steen and Dr Sands both of whom were not accepting hyponatremia played a part in Claire's death. Importantly he had not met Dr Webb in 2004. Accordingly, the minutes of the 2004 meeting represented the most contemporaneous note of Professor Young's views regarding repeat blood testing and these recorded that he believed blood testing every 24 hours was the standard practice in 1996. It was only in 2006, after he had received Dr Webb's statement, that he became aware Dr Webb would have carried out a repeat blood test if he had not misread the notes. Professor Young's response to this was to email the litigation manager stating this raised "substantial issues…which certainly could become significant at the inquest" and when he gave evidence to the Inquiry he advised the Chairman that he had not been aware of Dr Webb's view about repeat blood tests before this date (see transcript at para [40] above). All of this evidence demonstrated that the need for more frequent blood testing was "news" to

Professor Young. Additionally, Professor Young's view about the frequency of blood testing in 1996 was supported by the evidence of the coroner's independent expert, Dr Bingham, who stated that blood samples should be taken every 24 hours.

[113] Thirdly, the other treating clinicians, in particular Dr Steen, did not accept hyponatremia played a part in Claire's death until they gave evidence to the Inquiry. Professor Young was the first person to advise the parents that hyponatremia may have played a part in Claire's death, and he accordingly referred her case to the coroner. This Mr McGleenan submitted, demonstrated his honesty and the fact he was not part of a "cover up."

[114] Fourthly, Mr Roberts accepted in his evidence at the Inquiry that Professor Young had given the parents the information they had requested at the parents' meeting.

[115] Fifthly, in respect of the evidence Professor Young gave to the 2006 inquest Mr McGleenan submitted there was no evidence of dishonesty because the solicitor's notes of the evidence show that Professor Young was not permitted to answer a question about Claire's clinical care and accordingly there was no evidence he misled the inquest.

[116] On the basis of these evidential materials, Mr McGleenan submitted the case examiners were not acting irrationally in finding there was no or insufficient evidence of dishonesty.

Determination of question – Was the case examiners' decision irrational in light of the evidence?

Relevant Principles

[117] As appears from the 2004 Rules and the GMC guidance, case examiners are part of a procedure put in place by Parliament whereby the case examiners are engaged in a triage of complaints. They are tasked to determine whether there is a realistic prospect of proving, on the balance of probabilities, that a doctor's fitness to practise is currently impaired. In carrying out this role, they are making an evaluative judgment about how the allegations would fare before a Tribunal. The case examiners are, therefore, performing a quasi-prosecutorial function and it is one I consider which is analogous to the role of the PPS in directing prosecutions.

[118] I, therefore, consider the principles set out in *In the matter of an Application by Gerry Duddy and others for Judicial Review* [2022] NIQB 23, are applicable in the present context. In *Duddy*, the PPS decided not to prosecute Soldier F. On judicial review, the Divisional Court considered the test of prosecutorial decisions. The court quoted with approval the dicta of Lord Bingham in the case of *R v DPP ex parte Manning* [2001] QB 330, when he said at para [23] as follows:

> "…as the decided cases also make clear, the power of review is one to be sparingly exercised. The reasons for this are clear. The primary decision to prosecute or not to prosecute is entrusted by Parliament to the Director…In most cases the decision will turn not on an analysis of the relevant legal principles but on the exercise of an informed judgment of how a case against a particular defendant, if brought, would be likely to fare in the context of a criminal trial before (in a serious case such as this) a jury. This exercise of judgment involves an assessment of the strength, by the end of the trial, of the evidence against the defendant and of the likely defences. It will often be impossible to stigmatise a judgment on such matters as wrong even if one disagrees with it …"

[119] It further quoted with approval dicta of Lord Burnett in the case of *R(Monica) v DPP* [2018] EWHC 3508, when he stated at para [46]:

> "…where a CPS review decision is exceptionally detailed, thorough, and in accordance with CPS policy, it cannot be considered perverse.
>
> (2) A significant margin of discretion is given to prosecutors.
>
> (3) Decision letters should be read in a broad and common-sense way, without being subjected to excessive or overly punctilious textual analysis.
>
> (4) It is not incumbent on decision makers to refer specifically to all the available evidence. <u>An overall evaluation of the strength of a case falls to be made on the evidence as a whole,</u> applying prosecutorial experience and expert judgment."

[120] I consider these principles resonate in the present context and they further align with the *Bloor Homes* approach set out above.

[121] The case examiners provided a very detailed 40-page decision. During their decision the case examiners identify the key issues; set out the allegations; quote the relevant finding of the Inquiry; summarise the evidence and set out the tests they have to apply in their decision making.

[122] The case examiners rehearse that they have had regard to all the evidence. This is not mere lip service as their decision is replete with detailed references to the relevant evidence thereby demonstrating intimate knowledge of the factual

materials, and the case examiners then actively engage with the evidence in their decision making.

[123] At the end of this process, in respect of the central question regarding Professor Young's belief regarding repeat blood tests, the case examiners find:

> "…many of the comments made by Professor Young should be considered to have been made with the benefit of additional information and hindsight. This may also mean that comments made by Professor Young changed over time."

They then conclude by stating:

> "…the evidence before us indicates that Professor Young was consistent in saying he did not consider the actions taken in 1996 to have been out of keeping with usual practices at that time."

[124] When considering the allegations in respect of Professor Young's evidence to the inquest the case examiners acknowledge that questions in this setting can be nuanced and without an exact transcript it is difficult to evidence dishonesty. They therefore conclude:

> "We have not been provided with any cogent evidence that when Professor Young was asked a specific question by the Coroner he responded in a manner which he knew was wrong in an attempt to misdirect the proceedings."

[125] Having made these conclusions about his state of knowledge and his evidence to the inquest the case examiners conclude that there is no or no sufficient evidence of dishonesty in respect of the parents' meeting, the letter or the inquest and accordingly refuse to refer the allegations to the Tribunal.

[126] The case examiners were tasked to apply the realistic prospects test and in doing so, as the GMC guidance provides, the case examiners are entitled to "assess the weight of the evidence."

[127] The evidence which the applicant and the Inquiry relied on as demonstrating dishonesty was Professor Young's first statement to the Inquiry and his oral evidence to the Inquiry. Dr McGleenan's forensic analysis of this evidence shows, for the reasons set out by him, that it was open to the case examiners to place less weight on this evidence than the Inquiry did. Further, it was open to them to give more weight to the other available evidence including Professor Young's last statement to the Inquiry and his response statement to the GMC and the other evidence which demonstrated Professor Young's honesty.

[128] It is not the task of this court to review the merits of the decision but rather to determine whether the application of the prosecutorial-type analysis of the available evidence could rationally lead to a finding that there was no or insufficient evidence of dishonesty.

[129] I am satisfied the case examiners showed rigour and procedural fairness in their decision making. They gave careful consideration to all the materials; acknowledged both parties' perspectives; identified key passages from the Inquiry findings, considered all the statements including Professor Young's last statement to the Inquiry and his GMC response statement; looked at the transcripts; weighed up all the evidence and formed a view in respect of Professor Young's state of knowledge regarding repeat blood tests. I consider it was a rational choice for the case examiners to decide the realistic prospects test was not met based on their evaluation of the strength of the case applying their expertise and knowledge of how the case would fare at the Tribunal.

Was there a breach of GMC guidance because the case examiners resolved a factual dispute?

[130] Mr McQuitty additionally submitted, that the case examiners in resolving a complex dispute about Professor Young's belief in his favour, acted in breach of the GMC guidance which states they "should not, however, normally seek to resolve substantial conflicts of evidence."

[131] I reject this submission. The evidence did not consist of "conflicting" evidence but rather consisted of unchallenged written materials generated over several years arising from Trust meetings; correspondence with the parents; the inquest and the Inquiry. The case examiners were tasked to apply the realistic prospect test. This required them to weigh and balance all the evidence. This is what the case examiners did and in doing so they were not resolving conflicts of evidence but were rather assessing whether there was sufficient evidence of dishonesty to refer the case to the Tribunal.

Was the decision irrational because it displaced findings of the Inquiry and/or breached GMC guidance regarding "caution"?

[132] The heart of the applicant's case was that the Inquiry had made adverse findings against Professor Young which amounted to a prima facie case of dishonesty and, in such circumstances, it was irrational and in breach of GMC guidance regarding "caution", for the case examiners not to refer the case to the Tribunal for adjudication.

[133] There is no dispute that the findings of the Inquiry were a material factor to be taken into account and there is no complaint that the case examiners did not take them into account, which is not surprising given the decision is replete with

references to the Inquiry findings. The real complaint of Mr McQuitty, therefore, is that they did not give them sufficient weight.

[134] Weight however is a matter for the decision maker subject to rationality. In relation to the weight to be afforded to the Inquiry findings the case examiners were entitled to take the following matters into account.

[135] Firstly, there were limitations to the Inquiry findings as the Inquiry report observed at paragraph 1.58 as follows:

> "1.58 …In identifying what has gone wrong, I have inevitably criticised some individuals in organisations, my findings are not binding and are not determinative of liability.
> …
> 1.60 …In addition, and for the avoidance of doubt, where I permit myself comment expressing suspicion or concern, it is because I think it relevant. **It is not a finding of fact …**
> …
> 1.63 I am conscious that the individuals who are criticised were not able to defend themselves as they might in adversarial proceedings and were circumscribed in their right to make representations. I am also aware that individuals who are criticised may attract adverse publicity affecting both reputation and career. **Therefore, where critical comment is made of an individual, it must be assessed in the context of the limitations of the process."**

[136] Secondly, the Inquiry and the case examiners were tasked to carry out very different roles. The Inquiry's terms of reference required inquiry into, *inter alia,* "the information and explanations given to the respective families and others by the relevant authorities." In contrast, the case examiners' role was to determine whether the realistic prospect test was met in relation to Professor Young's fitness to practise. Whilst the findings of the Inquiry were a relevant consideration, the case examiners had to make their own judgment on the question before them. In *R(On the application of Squier) v GMC* [2015] EWHC 299 the court held:

> "The crucial point about the role of the disciplinary tribunal is that it should be the decision maker on the issues and evidence before it; it should not adopt the decision of another body, even of several judges, as a substitute for reaching its own decision on the evidence before it, on the different issues before it…it is the FTPP's statutory duty to decide the issues before it. None of that

> precludes the GMC under its Fitness to Practice Rules considering the judgments in a case in which evidence later at issue before the GMC was given. But they are not relevant for the purposes of substituting one judgment for the other, because it is the FTPP's statutory duty to decide the issues before it."

Accordingly, the case examiners were not bound by the Inquiry findings but rather had to make their own assessment of whether the realistic prospects test was met. This required them to carry out an evaluation of the strength of the case based on the evidence as a whole, applying prosecutorial experience and expert judgment – per *R (Monica) v DPP* at para [46]. As the decision makers the case examiners were entitled to place more or less weight on different pieces of evidence.

[137] Thirdly, in carrying out their role the case examiners were entitled to give no or little weight to the adverse findings of the Inquiry if their analysis of the evidential materials led to the conclusion the realistic prospects test was not met. For example, the case examiners were entitled to give little weight to the Inquiry's findings on the basis they considered the Inquiry's conclusions were based on a partial reading of Professor Young's first statement; referenced only part of his oral evidence and did not explain why they ignored his evidence that he did not know about Dr Webb's views until after the meeting and the letter was sent. Further, they were entitled to find that the Inquiry failed to engage with other evidence which demonstrated Professor Young did not hold this belief in 2004, namely the evidence that he had not met Dr Webb in 2004 and had access only to Claire's notes and records prior to the parents' meeting and the January letter. Additionally, they could consider that the Inquiry had failed to engage with Professor Young's final statement to the Inquiry and did not explain whether and if so, why they had rejected his explanation that his views about repeat blood testing evolved over time. Similarly, when the Inquiry found that Professor Young misled the Coroner, the case examiners were entitled to take the view that the Inquiry failed to engage with Professor Young's own evidence to the Inquiry that that he did not know about Dr Webb's views before the Inquest in 2006 and the Inquiry did not explain how they reached their conclusion that he had misled the inquest in circumstances where the solicitor's notes of the inquest demonstrated that Professor Young was prevented from answering the question about clinical mismanagement in Claire's case and therefore it was open to the case examiners to conclude that there was no evidence Professor Young had misled the coroner.

[138] Fourthly, when the case examiners were considering whether the realistic prospect test was met, they considered different evidence to the Inquiry. The evidence before the case examiners and the Inquiry was not identical. There was some overlap but importantly the case examiners had additional material. Unlike the Inquiry the case examiners had Professor Young's detailed response to the GMC in which he explained in detail how his view about repeat blood tests evolved over time. This was the first time he had had an opportunity to respond to criticisms of

his conduct as the Inquiry Report issued without there being a "Maxwellisation" process. It is apparent from their decision that they placed considerable weight on Professor Young's statement to the GMC. This is something they were entitled to do. Similarly, they were entitled to give less weight to some of the materials the Inquiry placed great weight upon and to place greater weight on other pieces of evidence.

[139] The court can only intervene if the decision is irrational. I consider the case examiners could rationally come to a different conclusion to the Inquiry on the issue of dishonesty having regard to the different role of the case examiners and the Inquiry; the different applicable tests; the different evidence before them, and because the case examiners were not bound by the Inquiry findings but were rather tasked to come to their own decision on the realistic prospects test which meant they had to assess the evidence and accordingly they were entitled to place different weight on different pieces of evidence.

[140] Mr McQuitty submitted that in coming to a different decision to the Inquiry the case examiners breached the GMC guidance which required the case examiners to "proceed with particular caution in reaching a decision to halt a complaint where the decision may be perceived to be inconsistent with a decision made by another public body with medical personnel or input…in relation to the same or substantially the same facts…"

[141] I consider particular caution was shown by the case examiners because in carrying out their task of determining whether the realistic prospects test was met, they conducted a painstaking and rigorous analysis of all the evidence; paid care and attention to Mr Roberts' complaint; recited the allegations; considered Professor Young's response to the allegations and considered the adverse findings of the Inquiry. In the exercise of their discretion, they gave different weight to different pieces of evidence which is something they were entitled to do. I consider the way in which they carried out their role, in determining whether the realistic prospects test was met, demonstrated they proceeded with "particular caution" in coming to a different finding to the Inquiry.

Was the decision irrational because the case examiners took into account irrelevant factors and failed to take into account relevant factors?

[142] Mr McQuitty submitted the case examiners' decision was based on irrelevant, irrational and bizarre reasoning. For example, when explaining why Professor Young did not act dishonestly at the parents' meeting, they stated that Professor Young's role was limited to fluid management and not Claire's clinical care, in circumstances where Professor Young's own evidence to the Inquiry was that he had expertise to comment on Claire's care. Further, when explaining why they found no evidence of dishonesty in respect of the letter, they gave an explanation which demonstrated a misunderstanding of the Inquiry's findings that Professor Young and not just Dr Steen had acted dishonestly in respect of the letter.

[143] Whilst criticisms can be made of the reliance placed by the case examiners upon the limits to Professor Young's role at the meeting, a fair reading of the whole decision demonstrates that this was not the sole or main reason for their finding that there was no evidence of dishonesty in respect of the parents' meeting. In their decision they referenced "the limited information available…to Professor Young ahead of that meeting" and accordingly they were highlighting that he only had access to Claire's notes and records and what he was advised by Dr Steen, who at that stage denied any mismanagement in respect of repeat blood tests. Accordingly, at this juncture they found Professor Young did not hold the belief the failure to carry out repeat blood tests amounted to mismanagement. Accordingly, they considered there was no dishonesty in not relaying such information at the meeting. The limits of Professor Young's role at the meeting was an additional reason why they found there was no evidence against Professor Young in respect of these allegations. I do not consider this additional reasoning makes the decision irrational.

[144] Although it may be arguable the case examiners did not fully appreciate the extent of the Inquiry's adverse findings against Professor Young in respect of the letter, the key issue which underpinned the allegations of dishonesty in respect of the letter again related to Professor Young's date of knowledge. On the central issue regarding the date of Professor Young's knowledge about the repeat blood tests the case examiners concluded:

> "We must therefore accept that many comments made by Professor Young (and others) should be considered to have been made with the benefit of additional information and hindsight. This may also mean that comments made by Professor Young changed over time…"

[145] Accordingly, any micro-criticism which can be made of the case examiners in this respect is of no great import. As the court in *Re Sands' Application* [2018] NIQB 80 at para [112] observed decisions:

> "…are not to be read and construed through the prism applicable to the decisions of a judicialised body. Rather a broader and more elastic approach is appropriate. This is nothing more and nothing less than the 'fairly and in bonam partem' exhortation of Lord Wilberforce: see [50] supra. To summarise, the applicable legal framework is one in which excessive legalism and rigid prescription are intruders."

[146] I am, therefore, satisfied that the case examiners' decision was not irrational on the basis it took into account irrelevant factors.

Did case examiners fail to give adequate reasons in breach of GMC guidance and the 2004 Rules?

Applicant's submissions

[147] Mr McQuitty submitted the case examiners failed to give cogent reasons for coming to a different conclusion to the Inquiry, contrary to GMC guidance and the 2004 Rules, as they failed to explain why they "must" accept Professor Young's comments were made with the benefit of additional information and hindsight.

Determination

[148] Rule 8 sub-para 4 requires the case examiners to give "reasons" for their decision. Similarly, the GMC guidance provides:

> "All parties should be able to understand why a decision has been taken even if they do not agree with the decision…It is important that the case examiners provide a detailed record of the reasons for their decisions."

[149] I consider that the provisions of the 2004 Rules and the GMC guidance are the same as the statutory duty to give reasons. The legal principles set out in *Blair Homes* and *South Bucks District Council v Porter (No 2)* [2004] 1 WLR 1953 are therefore relevant to this reasons challenge. Further as noted in *Sands:*

> "A reasons challenge will only succeed if the party aggrieved can satisfy the court that he has genuinely been substantially prejudiced by the failure to provide an adequately reasoned decision."

[150] The case examiners explained at the commencement of their decision that in coming to their conclusion they had had regard to all the evidence. Within the body of the decision they then carefully consider the relevant evidence including Professor Young's oral evidence to the Inquiry that he had not previously known Dr Webb's views until 2006; his last statement to the Inquiry and his statement to the GMC in which he explains how his views about blood testing evolved over time and his evidence to the Inquest in which they note questions are nuanced. The decision records their conclusion that Professor Young should be given the benefit of hindsight when he stated in his first statement that blood tests did not occur with sufficient frequency. Having made this finding on the key critical issue underpinning all the allegations of dishonesty they then concluded there was no or insufficient evidence to substantiate the allegations of dishonesty in respect of the meeting, the letter and the inquest.

[151] I am satisfied that the case examiners' decision addressed the principle important issue, namely the date of Professor Young's knowledge regarding the

need to carry out repeat blood tests and Mr Roberts understood the decision and the reasons for it. They did not engage in the forensic analysis that Mr McGleenan did before this court but that is not required. I am satisfied the reasons set out in the decision were intelligible and adequate to enable the applicant to understand what the case examiners had decided and why they had reached this conclusion.

[152] Accordingly, I am satisfied that there was no breach of the 2004 Rules or the guidance in respect of giving reasons.

Question 3 – Did the case examiners misapply the legal test for dishonesty?

[153] Mr McQuitty submitted the case examiners misapplied the test for dishonesty when they stated in their decision:

> "In the absence of evidence that Professor Young has made amendments to this letter which he categorically knew were false (rather than them being his own opinion at the time which may have been wrong or later subject to change) we do not consider there is sufficient evidence before us to suggest that his contribution to this letter was dishonest.
>
> We have not been provided with any cogent evidence that when Professor Young was asked a specific question by the coroner he responded with an answer which he knew was wrong in an attempt to misdirect the proceedings."

[154] Mr McQuitty contended the case examiners imported a higher threshold than that set down in *Ivey v Genting Casinos (UK) Ltd* [2018] AC 391 at para [74] when Lord Hughes stated:

> "…When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must

> appreciate that what he has done is, by those standards, dishonest."

[155] Mr McQuitty submitted that the case examiners committed a plain and material error of law by requiring evidence that Professor Young made amendments which he "categorically" knew were false. Mr McQuitty submitted the Supreme Court has expressly rejected the need to find that the defendant appreciated that what he had done was by objective standards dishonest. Secondly, he submitted the case examiners only applied the subjective half of the test and failed to apply the objective aspect of the test.

Determination of Question 3

[156] There are two parts to the *Ivey* test, namely the subjective test and the objective test. The first question the case examiners had to ascertain was the subjective state of Professor Young's knowledge or his belief as to the facts. Mr Roberts accepts and there is no doubt that the case examiners found that Professor Young subjectively did not believe that he provided false information to the parents at the meeting or in the letter or to the coroner. I do not consider the use of the word 'categorical' elevates the test. Categorically means "unambiguously" or "absolutely."

[157] Secondly, I do not find the use of the word 'categorical' in the case examiners' decision was applied to the second stage of the *Ivey* test. If the word "categorically" did relate to the application of the objective standard the fact the case examiners made such a finding is not fatal. The Supreme Court in *Ivey* simply stated that there was no requirement to make such a finding to establish dishonesty by the objective standard. The making of such a finding is not precluded, it is just not an essential ingredient of the offence.

[158] I am also satisfied that, once the case examiners concluded Professor Young subjectively did not believe in 2004 that there was mismanagement in Claire's case due to a failure to carry out repeat blood tests, they did not consider it necessary to expressly state that his conduct would not objectively be considered dishonest by the standards of ordinary decent people. Accordingly, I do not consider there was a misapplication of the legal test in respect of dishonesty.

Question 4 - Did the case examiners make a material error in failing to consider each individual allegation?

[159] Mr McQuitty submitted that the case examiners made a material omission as they failed to address the allegations at para 3(c)(iii) and (iv) and para 6, which alleged Professor Young was dishonest by omission in that he knew there were inaccuracies in the letter and did not correct them and omitted to give information to the coroner. Mr McQuitty submitted the case examiners' analysis focussed only on Professor Young's contribution to the letter and, accordingly, failed to deal with the

allegation he was dishonest by omission and the case examiners failed to address the allegations regarding his omission to provide certain information to the Coroner.

[160] He submitted that Rule 8 referred to "allegation" in the singular and therefore each allegation was distinct and separate and had to be dealt with by individual reasoning. He further submitted that this interpretation was endorsed in the GMC guidance which stated at para 124 under 'Recording Decisions':

> "It is important that the case examiners provide a detailed record of the reasons for their decisions."

[161] In *Dutta v GMC* [2020] EWC 1974 (Admin) the court considered the meaning of the term "allegation." The court held at para [83] that the term should be given a meaning that is:

> "…practical and workable for the purposes of the decision-making in question…But it must nonetheless be something that identifies a discrete, specific item of behaviour that is capable of being tied to a point in time …"

The court accepted that there were cases in which it was not easy to tease out and separate individual allegations from a mass of criticism but identified in that case that where there were separate and distinct topics, these were in substance separate allegations independent of one another, each of which could be considered in isolation as calling into question the doctor's fitness to practise.

[162] In the present case, the case examiners identified three discrete items of behaviour each tied to a point in time namely Professor Young's conduct relating to the parents' meeting, the letter and the inquest. The guidance for the formulation of allegations seeks to ensure that a full response is obtained from the person under investigation. The allegations in respect of each of these three topics were framed both in terms of omission and commission. The allegations of omission related to his failure to advise that failure to repeat the blood tests amounted to clinical mismanagement. The allegations of commission related to giving misleading information about the need for repeat blood tests.

[163] There is nothing in the guidance which says each and every allegation needs to be addressed in the decision. Accordingly, I consider a good sense approach should be applied.

[164] I am satisfied that the allegations of omission and commission are essentially two sides of the one coin and therefore Professor Young's conduct at the meeting, in the letter and at the inquest whether framed as omission or commission constituted one discreet specific item of behaviour and could be dealt with at the same time without the need to address every sub-paragraph of the allegations. The case

examiners addressed the three main topics and addressed the key issue underlying all the allegations of dishonesty, namely Professor Young's belief regarding repeat blood testing.

[165] The case examiners were aware of each and every allegation and rehearsed these in extenso in their written decision. It was not necessary for the case examiners to set out a repeat analysis in respect of each and every allegation in circumstances where they had concluded there was no evidence of dishonesty. I consider all the parties understood why the realistic prospects test was not met in respect of the allegations. Accordingly, I do not find that they committed a material error.

Rule 12 decision

[166] The submissions of the applicant regarding the Rule 12 decision mirrored the Rule 8 submissions with the main complaint being that the assistant registrar failed to find the Rule 8 decision was "materially flawed" by reason of the grounds of challenge already set out.

[167] I am satisfied the assistant registrar applied the correct test for review; had regard to all the evidence and documents and specifically set out that he had considered all the grounds for review presented by Mr Roberts. The assistant registrar then gave detailed reasons for his decision. I consider his decision was based on a proper evaluation of the evidence and complied with the relevant statutory provisions and the GMC guidance. Accordingly, I consider that there is no merit to any challenge to the Rule 12 decision.

Conclusion

[168] I refuse leave to apply for judicial review and will hear the parties in respect of costs.