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CO/1926/2022

In the High Court of Justice
King's Bench Division

Administrative Court

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 21st March 2023

Before:
MR JUSTICE RITCHIE

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BETWEEN

TERENCE PAUL GOLDEN

Appellant

- and –

THE NURSING AND MIDWIFERY COUNCIL

Respondent

The Appellant appeared in person
Matthew Cassells of NMC Legal appeared for the **Respondent**

Hearing date: 8th and 9th March 2023

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APPROVED JUDGMENT

Mr Justice Ritchie:

The Parties

1. The Appellant was a nurse and midwife whose name was on the register maintained by the Nursing and Midwifery Council ("NMC") and has been struck off.

2. Respondent is the NMC which struck the Appellant off the register after a disciplinary hearing.

Bundles

3. For the appeal I was provided with three bundles by the Respondent, the first two contained evidence and documents and the third contained authorities. I was also provided with five bundles by the Appellant, the fourth of which contained authorities.

The background

4. The Appellant is an independent midwife who was contacted by a pregnant woman, who I shall refer to as M, to be her private midwife for her planned birth in France. She did not wish to use the local French hospitals or State midwifery services or the private French midwifery services but instead wished to have a home birth in her house in France with an English registered midwife. This was her first child. She entered into a contract with the Appellant, which was drafted by him, for him to provide a minimum of three weeks of midwifery services before, during and after her calculated due date until the baby was 2/3 weeks old. She paid £3,000 for those services plus travel expenses.

5. The Appellant drove to France on the 31st of August 2019 and stayed in a caravan near M's house to provide the services before and after her stated due date which was the 9th of September 2019. Contractions did not start and her waters did not break (as I shall find below) before or on the due date. M and the Appellant agreed that the Appellant should leave on 17th September 2019 but should return urgently for the birth of her child. Subsequently, by emails and messages, M and the Appellant communicated but they eventually fell out and the Appellant regarded the contract as ended so he said so in an email he sent to M on the 8th of October 2019. That very day M went for a private scan of her baby near her village in France and a decision was made for her to have induction of labour. She went to a French hospital on 10th October where she gave birth to a live, healthy baby. Thankfully this is a not a claim for damages for personal injury or clinical negligence.

6. Both before and after the birth M complained to the Appellant about the standard of care he had provided and at one stage demanded a refund of £1,500. The Appellant denied any breach of duty. M then complained to the NMC and that complaint started a disciplinary process which led to a full fitness to practise panel ("FTPP") hearing which took place over 12 days between the 1st of April 2022 and

the 20th of April 2022. The Appellant did not attend the final hearing or take part in it. He did not provide his own witness list or bundle of documents for the FTPP final hearing in advance of the hearing when requested to do so or at all and failed to attend the pre-hearing case management meetings. He failed to fill in the case management forms. He failed to provide a signed and dated witness statement from himself or any witness statement containing his own evidence on the events in France in the summer of 2019.

7. The result of the hearing was that the Appellant was struck off the register of midwives held by the Respondent. The Appellant appeals the findings of fact and the determination that he was unfit to practise and the sanction of striking off.

Law and procedure

NMC regulatory functions

8. The NMC's functions in respect of allegations of misconduct against registered nurses and midwives are governed by the *Nursing and Midwifery Order 2001* ("the Order"). The proceedings of the FTPP are governed by the *Nursing and Midwifery Council (Fitness to Practise) Rules 2004* ("the Rules"). The over-arching objective of the NMC in exercising its functions is the protection of the public (Article 3(4) of the Order). The pursuit of this over-arching objective involves the following integral objectives: (1) the protection, promotion and maintenance of the health, safety and wellbeing of the public; (2) the promotion and maintenance of public confidence in the profession; (3) the promotion and maintenance of proper standards and conduct by registered members of the profession (Article 3 (4A) of the Order).

9. By virtue of Rule 6C(2)(a)(ii), the Fitness to Practise Committee must consider any allegation referred to it by the Case Examiners and if, having considered the allegation, it considers that it is well founded, must proceed to make one of a number of prescribed decisions, which by Article 29(5) (a) – (d) include: a striking off order, a suspension order, a conditions of practise order or a caution order.

Appeals

10. Articles 29(9) and 38 of the Order allow a registrant to appeal against a decision made by the FTPP. By virtue of Article 38(3) of the Order, the Court is empowered to: (a) dismiss the appeal; (b) allow the appeal and quash the decision appealed against; (c) substitute for the decision appealed against any other decision which the FTPP could have made, or (d) remit the case to the FTPP concerned or the Council, as the case may be, to be disposed of in accordance with the directions of the Court.

11. By virtue of *Civil Procedure Rule*s r. 52.21(3) the Court will only grant such an appeal where the decision of the lower court (FTPP) was: (a) wrong or (b) unjust because of a serious procedural or other irregularity.

12. Under CPR r. 52.21 and PD52 para. 19.1, in appeals under Art. 38 of the Order every appeal must be supported by written evidence and "if the court so orders, oral evidence and will be by way of re-hearing".

13. The approach to be taken by the Courts in relation to appeals such as this has been considered in *Cheatle v General Medical Council* [2009] EWHC 645. Cranston J. at paras. 12-15 summarised the procedure thus:

> **"Appeals from a Fitness to Practise Panel**
> 12. The appeal to this court from a Fitness to Practise Panel is under section 40 of the 1983 Act. Section 40 (7) permits the court to dismiss the appeal, to allow it and to quash a direction for suspension, to substitute a different direction or to remit the case. The appeal is by way of a re-hearing. The relevant practice direction offers no guidance as to what this means: see CPR 52 PD. 116 (2). Clearly it is not an appeal confined to a point of law, but neither at the other end of the spectrum is it a de novo hearing, where the court hears the witnesses giving evidence again. The basis of intervention appears to be broader than that for judicial review. On at least one view there is a tension between two Court of Appeal decisions as to the approach to be adopted. At first instance in *Meadow v General Medical Council* [2006] EWCA Civ 1390, [2007] QB 462, Collins J said that an appeal was not limited to review, although the court would not interfere with a Fitness to Practise Panel's decision unless it was clearly wrong. The Court of Appeal agreed, but doubted that the word "clearly" added anything (paragraph 125). Auld LJ said (Sir Anthony Clarke MR and Thorpe LJ agreed) (paras 69 and 282):
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> > "… it is plain from the authorities that the Court must have in mind and give such weight as is appropriate in the circumstances to the following factors: (i) The body from whom the appeal lies is a specialist Tribunal whose understanding of what the medical profession expects from its members in matters of medical practice deserve respect: (ii) The Tribunal had the benefit, which the Court normally does not, of hearing and seeing the witnesses on both sides; (iii) The questions of primary and secondary fact and the over-all value judgment to be made by Tribunal, especially the last, are akin to jury questions to which there may be reasonably be different answers." (para 197).
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> 13. *Raschid and Fatnani v General Medical Council* [2007] EWCA Civ 46 ; [2007] 1 WLR 1460 was an appeal on sanction. In the first case Collins J had substituted a suspension of one month for one of twelve months, and in the second a suspension of twelve months for

erasure. The GMC's appeals were allowed. Laws LJ reviewed Privy Council decisions on the appellate role in GMC matters. In a judgment with which Chadwick LJ and Sir Peter Gibson agreed Laws LJ held that those decisions established two strands of learning, first, that a principal purpose of a Fitness to Practise Panel was the preservation and maintenance of public confidence in the profession rather than the administration of retributive justice, and secondly, it was necessary to accord special respect to its judgment. The High Court would correct material errors of fact and of law and it would exercise a judgment, though distinctly and firmly a secondary judgment, as to the application of the principles to the facts of the case (para 20). Laws LJ expressly disagreed with the approach adopted by Collins J in Meadow, unless it was read in the context of the two strands in the learning (para 21).

14. The hearing before the Court of Appeal in Raschid took place just after the Court of Appeal gave judgment in Meadow but it was not drawn to the attention of the court deciding Raschid. These two decisions were reviewed by Wyn Williams J in *Rumbold v GMC* [2007] EWHC 2569 (Admin), [2008] LS Law Med 169, but he did not need to decide which was correct (paras 17-30). See also *Cohen v GMC* [2008] EWHC 581 (Admin), [2008] LS Law Med 246 paras 19-26.

15. In my view the approaches in Meadow and Raschid are readily reconcilable. The test on appeal is whether the decision of the Fitness to Practise Panel can be said to be wrong. That to my mind follows because this is an appeal by way of rehearing, not review. In any event grave issues are at stake and it is not sufficient for intervention to turn on the more confined grounds of public law review such as irrationality. However, in considering whether the decision of a Fitness to Practise Panel is wrong the focus must be calibrated to the matters under consideration. With professional disciplinary tribunals issues of professional judgment may be at the heart of the case. Raschid was an appeal on sanction and in my view professional judgment is especially important in that type of case. As to findings of fact, however, I cannot see any difference from the court's role in this as compared with other appellate contexts. As with any appellate body there will be reluctance to characterise findings of facts as wrong. That follows because findings of fact may turn on the credibility or reliability of a witness, an assessment of which may be derived from his or her demeanour and from the subtleties of expression which are only evident to someone at the hearing. Decisions on fitness to practise, such as assessing the seriousness of any misconduct, may turn on an exercise of professional judgment. In this regard respect must be accorded to a

> professional disciplinary tribunal like a Fitness to Practise Panel. However, the degree of deference will depend on the circumstances. One factor may be the composition of the tribunal. In the present case the Panel had three lay members and two medical members. For what I know the decision the Panel reached might have been by majority, with the three lay members voting one way, the two medical members the other. It may be that some at least of the lay members sit on Fitness to Practise Panels regularly and have imbibed professional standards. However, I agree with the submission for the Appellant in this case that I cannot be completely blind to the current composition of Fitness to Practise Panels."

14. In the Court of Appeal in *Sastry & Okpara v General Medical Council* [2021] EWCA Civ 623, Nicola Davies LJ ruled on the approach as follows at para. 102:

> "102. Derived from Ghosh are the following points as to the nature and extent of the section 40 appeal and the approach of the appellate court:
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> i) an unqualified statutory right of appeal by medical practitioners pursuant to section 40 of the 1983 Act ;
> ii) the jurisdiction of the court is appellate, not supervisory;
> iii) the appeal is by way of a rehearing in which the court is fully entitled to substitute its own decision for that of the Tribunal;
> iv) the appellate court will not defer to the judgment of the Tribunal more than is warranted by the circumstances;
> v) the appellate court must decide whether the sanction imposed was appropriate and necessary in the public interest or was excessive and disproportionate;
> vi) in the latter event, the appellate court should substitute some other penalty or remit the case to the Tribunal for reconsideration."

15. Thus, it is clear to me from the Order, the CPR and the case law that for appeals such as this against the NMC FTPP's decisions the following approach is used:

> a. The right to appeal is not qualified by the filter of needing permission to appeal.
> b. The appeal may concern alleged errors of law but is not confined to such and may also cover appeals against decisions of fact, rulings on procedure and decisions on sanctions.
> c. The appeal is a rehearing but it is not a de novo hearing so the witnesses are not called to give evidence again. The

evidence is generally in written form (witness statements, transcripts and documents) but some oral evidence may be admitted if the Court so orders.

d. The Court's function is a review of the panel's decision, but it is not limited to a supervisory review (so not applying a test akin to judicial review), it is a broader approach to determine whether the panel's decision was wrong or there was a serious procedural or other irregularity.

e. In relation to findings of fact, the Court is entitled to exercise its own judgment on whether the evidence supports the panel's findings in relation to whether any decision was wrong. However always bearing in mind that the FTPP had the benefit of seeing and hearing cross examination and evidence whereas the appeal court generally does not, so credibility assessment is primarily a matter for the FTPP.

f. In considering whether a decision of the FTPP was wrong, the focus must be calibrated to the matters under consideration. In relation to findings which reflect professional judgment concerning standards of professional practice and conduct, the appeal court will give due deference to the judgment of the professional body, the specialist tribunal entrusted with the maintenance of the standards of the profession.

Proceeding in the absence of the member accused

16. The FTPP proceeded in the absence of the Appellant. Rule 21 of the Rules states:

> "**Absence of the practitioner**
> 21.(1) This rule shall not apply to hearings at which the Committee is considering whether to make, revoke, confirm, vary or replace an interim order.
> (2) Where the registrant fails to attend and is not represented at the hearing, the Committee:
> (a) shall require the presenter to adduce evidence that all reasonable efforts have been made, in accordance with these Rules, to serve the notice of hearing on the registrant;
> (b) may, where the Committee is satisfied that the notice of hearing has been duly served, direct that the allegation should be heard and determined notwithstanding the absence of the registrant; or
> (c) may adjourn the hearing and issue directions."

17. The leading case on proceeding in the member's absence is *General Medical Council v Adeogba and Visvardis* [2016] EWCA Civ 162, which sets out the

approach to be taken by regulatory tribunals. At paras. 14-23 Sir Brian Leveson ruled as follows:

> "14. … (*R v Jones [2002] UKHL 5; [2003] 1 AC 1*) where Lord Bingham (with whom Lord Nolan, Lord Hoffmann, Lord Hutton and Lord Rodger agreed) approved the guidance set out above (with the specific exception of that contained in [22(5)(viii)]) and emphasised, at [6], that the discretion to continue in the absence of a defendant should be "exercised with great caution and with close regard to the overall fairness of the proceedings". Lord Bingham observed that if attributable to involuntary illness or incapacity it would very rarely "if ever" be right to exercise discretion in favour of commencing the trial unless the defendant is represented and asks that the trial should begin. As for the guidance, Lord Bingham considered it "generally desirable" that a defendant be represented even if he had voluntarily absconded but also made it clear (at [14]):
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> > "I do not think that "the seriousness of the offence, which affects defendant, victim and public"… is a matter which should be considered. The judge's overriding concern will be to ensure that the trial, if conducted in the absence of the defendant, will be as fair as circumstances permit and lead to a just outcome. These objects are equally important, whether the offence charged be serious or relatively minor."
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> 15. Lord Hoffmann (agreeing with Lord Rodger) expressed himself (at [19]) "not comfortable" with the notion of waiver which required "consciousness of the rights which have been waived"; he preferred to say that they "deliberately chose not to exercise their right to be present or to give adequate instructions to enable lawyers to represent them".
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> 16. These principles were considered by the Judicial Committee in *Tait v Royal College of Veterinary Surgeons ([2003]UKPC 34, (2003) WL 1822941*), which concerned an application for a second adjournment of a disciplinary hearing on the grounds of ill health (hypertension) unsupported by medical evidence. The refusal to adjourn was quashed on the grounds that the direction did not comply with the requirements in *Jones*. Although citing the Court of Appeal's checklist in *Hayward* as approved by the House of Lords on appeal in *Jones*, the Board identified (at [5]) "the seriousness of the case against the defendant" as a relevant factor. In that regard, it does not appear that the Board's attention was drawn to the exception that Lord Bingham specifically made in

relation to seriousness of the offence constituting an exception to Lord Bingham's approval.

17. In my judgment, the principles set out in *Hayward*, as qualified and explained by Lord Bingham in *Jones*, provide a useful starting point for any direction that a legal assessor provides and any decision that a Panel makes under Rule 31 of the 2004 Rules. Having said that, however, it is important to bear in mind that there is a difference between continuing a criminal trial in the absence of the defendant and the decision under Rule 31 to continue a disciplinary hearing. This latter decision must also be guided by the context provided by the main statutory objective of the GMC, namely, the protection, promotion and maintenance of the health and safety of the public as set out in s. 1(1A) of the 1983 Act. In that regard, the fair, economical, expeditious and efficient disposal of allegations made against medical practitioners is of very real importance.

18. It goes without saying that fairness fully encompasses fairness to the affected medical practitioner (a feature of prime importance) but it also involves fairness to the GMC (described in this context as the prosecution in *Hayward* at [22(5)]). In that regard, it is important that the analogy between criminal prosecution and regulatory proceedings is not taken too far. Steps can be taken to enforce attendance by a defendant; he can be arrested and brought to court. No such remedy is available to a regulator.

19. There are other differences too. First, the GMC represent the public interest in relation to standards of healthcare. It would run entirely counter to the protection, promotion and maintenance of the health and safety of the public if a practitioner could effectively frustrate the process and challenge a refusal to adjourn when that practitioner had deliberately failed to engage in the process. The consequential cost and delay to other cases is real. Where there is good reason not to proceed, the case should be adjourned; where there is not, however, it is only right that it should proceed.

20. Second, there is a burden on medical practitioners, as there is with all professionals subject to a regulatory regime, to engage with the regulator, both in relation to the investigation and ultimate resolution of allegations made against them. That is part of the responsibility to which they sign up when being admitted to the profession.

21. Third, in relation to medical practitioners, it is significant that under s. 31(4) of the 1983 Act, it is the duty of the Registrar to keep the registers correct and to make the necessary alterations in the addresses, qualifications and other registered particulars of registered persons. Accordingly, the GMC requires doctors to provide a current registered address. Not doing so is itself a

significant failure and risks removal from the register (although it is clear that erasure in these circumstances is quickly remedied by application and the provision of a current address: see The General Medical Council (Restoration following Administrative Erasure) Regulations Order of Council 2004). Therefore, the fact that a practitioner has not updated contact details with the GMC (particularly when he is aware that he is then subject to disciplinary investigation) is unlikely to provide a reasonable explanation for failure to participate in the process, sufficient to require the Panel to adjourn consideration of a fixed disciplinary hearing.

22. This conclusion is underlined by the fact that Rule 31 specifically mandates that "all reasonable efforts" to have been made to serve the practitioner with notice of the hearing in accordance with 2004 Rules. Thus, in *Jatta v Nursing and Midwifery Council [2009] EWCA Civ 824*, the respondent was no longer at the address which he had registered but failed to provide a current address. The Court of Appeal held that it was open to the relevant disciplinary committee to proceed to hear the case when he did not appear. Lloyd LJ put the matter (at [31]):

> "… in the absence of a notified fresh address the council was bound to send notice to the old registered address and could not be thwarted in its desire to take or continue these disciplinary proceedings by knowing that the only address they had was an address at which the document would not come to his attention."

23. Thus, the first question which must be addressed in any case such as these is whether all reasonable efforts have been taken to serve the practitioner with notice. That must be considered against the background of the requirement on the part of the practitioner to provide an address for the purposes of registration along with the methods used by the practitioner to communicate with the GMC and the relevant tribunal during the investigative and interlocutory phases of the case. Assuming that the Panel is satisfied about notice, discretion whether or not to proceed must then be exercised having regard to all the circumstances of which the Panel is aware with fairness to the practitioner being a prime consideration but fairness to the GMC and the interests of the public also taken into account; the criteria for criminal cases must be considered in the context of the different circumstances and different responsibilities of both the GMC and the practitioner."

18. I take from this ruling that when faced with the intentional absence of the Appellant the FTPP should take into account the following matters when exercising its discretion under Rule 21 and assessing fairness:

    a. Fairness encompasses fairness to the affected practitioner. This is a feature of prime importance.
    b. Fairness also involves fairness to the NMC which has serious statutory regulatory responsibilities to fulfil to protect the public.
    c. The principles set out in *R v Hayward*, *R v Jones* and *R v Pruvis* [2001] EWCA Crim 168 as modified by the House of Lords in *R v Jones* [2002] UKHL 5 provide the starting point but the analogy between criminal prosecution and regulatory proceedings should not be taken too far, not least because a regulator has no power by which it can enforce attendance by the practitioner accused of misconduct.
    d. It would run counter to the protection, promotion and maintenance of the health and safety of the public if a practitioner could effectively frustrate or disrupt the process and challenge a refusal to adjourn when the practitioner has deliberately frustrated or failed to engage in the process.
    e. The question of proceeding in the absence must be considered in the light of the duty on professionals who are subject to a regulatory regime to engage with their regulator including a duty to provide adequate real and digital addresses and contact details at which they can be contacted, witness lists and bundles of documents relied upon.

Evidence where a practitioner does not engage

19. Evidence before a FTPP final hearing of the NMC is usually managed by a cae conference and if necessary a pre-hearing preliminary meeting. Rule 18 states:

> "**Preliminary meetings**
> 18.(1) Before any allegation is considered by a Committee at a hearing in accordance with the provisions of this Part, that Committee or the Chair of the Committee may hold a preliminary meeting if such a meeting would, in its or her opinion, assist the Committee to perform its functions.
> (2) A preliminary meeting referred to in paragraph (1) shall be:
> (a) chaired by the Chair of the Committee considering the allegation;
> (b) held with a legal assessor in attendance; and
> (c) held in private with the parties, their representatives and any person the Chair or Committee considers appropriate.
> (3) The Chair of the preliminary meeting may give the directions mentioned in article 32(3) of the Order.

(4) The Chair of the preliminary meeting shall give the parties not less than 14 days notice of any preliminary meeting.

(5) Directions given by the Chair of the preliminary meeting may include, but shall not be limited to:

(a) time limits for the service of evidence and disclosure of expert evidence (if any);

(b) a requirement that each party provide an estimate as to the length of the hearing and any dates on which they or any witnesses would not be able to attend the hearing;

(c) where facts are not in dispute, or the issue of misconduct is admitted, a requirement that the parties produce a statement of agreed facts;

(d) save in the case of an allegation of a kind referred to in article 22(1)(a)(iv) of the Order, a requirement that the parties state whether or not the health of the practitioner will be raised as an issue in the proceedings, and if so, whether, in their view, medical reports should be obtained;

(e) a requirement that a party call the author of any expert report;

(f) where agreed between the parties, a direction that the witness statement of a witness shall stand as the evidence in chief of that witness;

(g) where the Committee is considering—

(i) an allegation that the registrant's fitness to practise is impaired by reason of her physical or mental health, or

(ii) whether to make, revoke, confirm, vary or replace an interim order, whether the proceedings should be held in public or private;

(h) special measures to be put in place at the hearing for vulnerable witnesses;

(i) a direction for an adjournment of the preliminary meeting or that a further preliminary meeting should be held; and

(j) a direction that the registrant, within such period as the Chair may specify in the written confirmation referred to in paragraph (8),—

(i) undertake an examination or other assessment of the registrant's knowledge of English as specified in the written confirmation referred to in paragraph (8), and

(ii) provide the [Fitness to Practise]129 Committee with evidence of the result of that examination or other assessment in the form required by rule 6B(3C).] 130

(6) At the preliminary meeting, the legal assessor may give a preliminary opinion for the purpose of resolving questions of law or admissibility of evidence.

> (7) Notwithstanding paragraph (6), decisions as to whether or not any evidence is to be admitted at the hearing shall be taken by the Committee considering the allegation.
> (8) The Chair of the preliminary meeting must—
> (a) keep a record of the directions given;
> (b) send written confirmation of such directions to the parties promptly; and
> (c) where a direction is made pursuant to paragraph (5)(j), inform the registrant of the matters set out in rule 6B(3D)."

20. As will become apparent below the Appellant did not agree to attend the case conference proposed by the NMC so none of nothing was agreed by way of evidence and no directions resolving issues were made. Nor did the Appellant provide, for the final FTPP hearing, a bundle or a witness statement from himself or statements from any supporting witness.

21. There are three authorities dealing with what, if any, material provided by a practitioner during the preparation of the case by the regulator should be provided to the FTPP which is determining the case when the practitioner fails to attend the final hearing.

22. In *Thorneycroft v Nursing Midwifery Council* [2014] EWHC 1565 (Admin) Andrew Thomas QC sitting as a deputy High Court Judge considered the position where a practitioner provides documents for his fitness to practise hearing. The facts were that the appellant wrote to the respondent stating that he no longer intended to attend the hearing. He said that he could not afford to attend nor to pay the costs of his representative. He enclosed documents in support of his case, including an updated statement of his own, a letter from a witness and an updated statement from another witness. There were also 11 testimonials to his professionalism, personality and good character. On the issue of when these should have been provided to the panel by the NMC Andrew Thomas QC ruled as follows:

> "57. It is clear to me that the Panel were not provided with the material which they needed to perform the necessary balancing exercise. Although it is now conceded that the statements of Ms 1 and Ms 2 was the sole and decisive evidence on all but one of the charges, the Panel were not told that at the time. The Panel were not given the opportunity to read the Appellant's witness statement before they took their decision and would not have been aware of the the potential motives which he had suggested these two witnesses might have to lie. The issues raised by the Appellant were not outlined to the Panel. Insufficient consideration was given to the fact that, despite some reference to ill health, the witnesses did not appear to have good reasons for their failure to attend. Their

> reluctance to attend in itself was capable of undermining the credibility of their evidence. There was no consideration of the further steps which could have been taken to compel the attendance of the witnesses. There was no reference to the serious consequences for the Appellant if the evidence was admitted and accepted.
> 58. There was a second material error. In my view, the Panel should have been provided at the fact-finding stage with all of the documents which the Claimant had submitted. The relevance and admissibility of character evidence for the purpose of assessing facts can be controversial. However, as Donkin v Law Society shows, there are cases where character evidence goes to the credibility of the allegation itself. In my judgment, in the circumstances of what was being alleged in the present case many of the statements submitted by the Appellant were relevant and admissible for that purpose.
> 59. However, whether or not this view is correct, the error in this case was more fundamental. The decision on admissibility was a judgment for the Panel to make, not the Legal Assessor or the Case Presenter. In the absence of the Appellant, the only proper way for the Panel to judge the relevance and admissibility of the statements was to read them for themselves. That was not done. The transcript shows that, on the advice of the Legal Assessor, the Panel left it to the Case Presenter to decide whether or not they should read the statements."

23. In *GMC v Adeogba & Visvardis* [2016] EWCA Civ 162, the Court of Appeal was dealing with a situation where a practitioner failed to engage effectively with the hearing process, preferring mount collateral attacks instead. Sir Brian Leveson P. ruled as follows:

> [104] As for Dr Visvardis' intention to attend, whether or not he had so asserted, the reality is that he had done nothing to comply with the directions to disclose documents on which he intended to rely or otherwise to participate in the process. Rather, he had embarked on a collateral attack of the process. This was not, as the judge concluded, a "simple fact" of absence; it is clear from the material that this was deliberate disruption on the basis that Dr Visvardis felt that he was entitled to challenge the decision to refer the case to a hearing and was not prepared to leave this preliminary issue to be considered as part of his defence before the Panel.
> [105] In truth, there was absolutely no reason for Dr Visvardis not to participate in this hearing. He should have prepared for it and taken steps to arrange representation (if that is what he wished): equally, based in Greece, he should have long since prepared to

> travel in order to participate. Further, having declined to attend on the first day (even if only to raise the issue of cancellation), when he received notice that the hearing would not be cancelled, it was open to him then to travel, alert the Panel to the fact that he was attending on the following day and seek the re-commencement of the hearing or an adjournment of whatever length he then wished; that application would then have fallen to be considered on its merits.
> [106] The effect of the decision of Judge Bird was to permit Dr Visvardis effectively to require the consideration of the complaint against him not with the benefit of his co-operation and submissions which could then be adjudicated upon but rather by collateral application unrelated to the merits. If Dr Visvardis wished to complain about the vires of the procedure, it was open to him to do so ultimately by means of judicial review. What he was not entitled to do was to conduct the case management stages in such a way that failed to deal with the issues which required to be addressed especially in relation to disclosure of documents upon which he intended to rely. In my judgment, the Panel was entitled to conclude that he was not engaged in the process.
> [107] As for the concern expressed by the Judge that the account advanced by the GMC would go unchallenged, as with Dr Adeogba, if such a consideration was to prevail above all others, cases would never be heard. Even without referring to the difficulties caused by the absence of Dr Visvardis, the Panel referred to the need to proceed with "the greatest care" and "great caution" which can only refer to this problem. Further, in this case, the practitioner had submitted an extensive response under Rule 7 to which the Panel were referred."

24. In *El-Huseini v General Medical Council* [20212] EWHC 2022 (Admin) Jacobs J, at paras. 110 – 112, considered the responsibility on tribunals and regulators to sift through documents where a practitioner supplied large quantities of unindexed or uncategorised documents:

> "[110] In the present case, there is in my view nothing which begins to warrant the correction of the relevant findings of fact that the MPT made. The MPT heard live evidence from various witnesses who were present at the material time, and its factual conclusions were based upon the evidence of those witnesses and contemporaneous documents. Dr El-Huseini did not himself give evidence to the MPT, and did not provide a witness statement pursuant to the orders made by the MPTS. Although reliance is now placed by Dr El-Huseini upon an e-mail sent to Dr Borman on 23 June 2011, I was not shown any documentation which supported

> the proposition that this e-mail was ever shown to the MPT. It is therefore not surprising that the MPT did not refer to it.
> [111] It is clear from other parts of the MPT's decision, however, that the MPT did not simply accept the case advanced by the GMC, relying on the evidence of witnesses called by the GMC, without regard to Dr El-Huseini's case as expressed in the materials which existed. For example, paragraph 31 of the decision (which dealt with an allegation that the MPT held was not proven) referred to an account of events that Dr El-Huseini had given at a disciplinary hearing of the UHCW in February 2013. If the e-mail of 23 June 2011 had been provided to the MPT, it is likely that the MPT would have considered it. However, it was under no obligation to carry out an exercise of sifting through large quantities of unindexed or uncategorised documentation provided by a doctor in order to determine what if any relevance it might have: see *Sanusi v General Medical Council* [2019] EWCA Civ 1172, para [84].
> [112] It is also important to bear in mind that the nature of the proceedings before the MPT is adversarial, not inquisitorial: see *R (Russell) v General Medical Council* [2008] EWHC 2546 (Admin) para [35]. If as in the present case, a doctor does not provide a witness statement, does not attend the hearing so as to explain his position on the facts and give evidence about them, and does not cross-examine the relevant witnesses, then there will usually be little prospect of a successful challenge to MPT's fact-findings, on disputed issues, based on evidence from witnesses who did actually give statements and oral evidence to the tribunal. This is so whether or not the doctor had made statements on disputed issues in documents after the event."

25. I glean from these rulings that where a practitioner fails to engage with the NMC in preparation for the final hearing, fails to provide a bundle of documents to be relied on or witness statements for the hearing and fails to attend, the FTPP does not have to guess what the practitioner wants to put before the FTPP for the final hearing. Nor does the NMC have to sift through the historic case correspondence or the historic documents previously sent by the practitioner during, for instance, the interim suspension hearings and appeals from interim orders, to construct evidence files which the practitioner himself has not identified, provided or prepared for the final hearing. This is so when the practitioner is refusing to engage contrary to his duty to cooperate and in particular when he is being positively obstructive or disruptive to the process.

Insurance for midwives in England and Wales

26. Before I turn away from the law, to give context to this case I should look at Article 12A of the Order which states:

"**Indemnity arrangements**

12A.—(1) Each practising registrant must have in force in relation to that registrant an indemnity arrangement which provides appropriate cover for practising as such.

(2) For the purposes of this article, an "indemnity arrangement" may comprise—

(a) a policy of insurance;

(b) an arrangement made for the purposes of indemnifying a person;

(c) a combination of the two.

(3) For the purposes of this article, "appropriate cover", in relation to practice as a registered nurse, midwife or nursing associate means cover against liabilities that may be incurred in practising as such which is appropriate, having regard to the nature and extent of the risks of practising as such.

(4) The Council may make rules in connection with the information to be provided to the Registrar—

(a) by or in respect of a person applying for registration (including an application for restoration or readmission) for the purpose of determining whether or not the Registrar is satisfied that if the person is registered, there will be in force in relation to that person by the time that person begins to practise, an indemnity arrangement which provides appropriate cover;

(b) by or in respect of a person applying for renewal of their registration for the purpose of determining whether or not the Registrar is satisfied that if the person's registration is renewed, there will be in force in relation to that person by the time that person resumes practice, an indemnity arrangement which provides appropriate cover; and

(c) by or in respect of a registrant for the purposes of determining whether at any time there is in force in relation to the registrant an indemnity arrangement which provides appropriate cover.

(5) Rules made under paragraph (4) may require information to be provided—

(a) at the request of the Registrar; or

(b) on such dates or at such intervals as the Registrar may determine, either generally or in relation to individual registrants or registrants of a particular description.

(6) The Council may also make rules requiring a registrant to inform the Registrar if there ceases to be in force in relation to that registrant appropriate cover under an indemnity arrangement.

(7) The Council may also make rules requiring a registrant to provide the Registrar with such information as is necessary for the

purpose of satisfying the Registrar that there is or will be in force in relation to that registrant appropriate cover provided under an indemnity arrangement by an employer.

(7A) For the purposes of verifying that information, the Registrar may disclose to any person information relating to a person's indemnity arrangement which is provided to the Council by virtue of rules made under paragraph (4) or (7).

(8) **If a registrant is in breach of paragraph (1)—**

(a) the Registrar may remove that person from the register; or

(b) the person's fitness to practise may be treated for the purposes of article 22(1)(a)(i) as being impaired by reason of misconduct, and the Registrar may accordingly refer the matter to persons appointed by it under article 22(5)(b)(i) (where rules under article 23 provide) or to a Practice Committee under article 22(5)(b)(ii).

(9) If an applicant breaches rules under paragraph (4), or there is a breach of rules under that paragraph in respect of the applicant the Registrar may refuse the applicant's application for—

(a) admission (or readmission) to the register;

(b) restoration to the register; or

(c) renewal.

(10) If a registrant breaches rules under paragraph (4)(b) or (c), that person's fitness to practise may be treated for the purposes of article 22(1)(a)(i) as being impaired by reason of misconduct, and the Registrar may accordingly refer the matter to persons appointed by it under article 22(5)(b)(i) (where rules under article 23 provide) or to a Practice Committee under article 22(5)(b)(ii)."

(My emboldening)

27. So inadequate or lack of insurance is a striking off offence in itself. During the appeal the Appellant admitted working as a midwife in France in the summer of 2019 without insurance or registration in France contrary to the NMC Order and contrary to the French Law which required registration with the French Order of Midwives and proper insurance. In evidence he went further than the NMC's own expert who had given evidence that registration was required by law and that insurance was required by law in France. The Appellant provided to the Court a document he typed up as an extract from APAAD (Association Professionnelle de l'Accouchement Accompagne a Domicile) on which he relied. This is the document with emboldening by the Appellant, not by me:

"**APAAD French Council for Home Birth Midwives**
contact@apaad.fr https://www.apaad.fr/
Statement

> APAAD works in France to regularize the issue of accompanied childbirth at home Currently AAD is not prohibited, neither for women nor for midwives in our country.
> **However French midwives have no possibility of insuring for this activity [homebirth].**
> If failure to insure is punishable by a fine of £45,000 and may lead to a ban on practice. No midwife has been prosecuted on this count since the publication of the Kushner law in 2004 because the insurance default is not their fault but that of the insurance companies who refuse to establish contracts for APAAD.
> Our professional unions and the association of liberal midwives support APAAD and work alongside us. On the other hand, the National Council of the Order of Midwives, adopts an ambiguous position not pursuing the AAD midwives for this reason, but neither seeking to resolve this problem.
> **In border regions, several midwives from neighboring (sic) countries come to offer their home care to French citizens who are struggling to find a practitioner, due to this precarious situation.**
> [This statement has been provided specifically to assist the court in the matter of Golden v NMC 2021] (Translated from French 23 February 2021)"

28. To understand the history of the lead up to the Appellant's behaviour in France in 2019 we also need to go back to *R (Beety) v NMC & Independent Midwives UK* [2017] EWHC 3232 (Admin). The claimants applied for judicial review of a decision of the Registrar of the NMC dated 20 December 2016, that an indemnity/insurance arrangement with Lucina Ltd providing cover to members of Independent Midwives UK was not "appropriate" for the purposes of article 12A of the Order and their registration with the NMC. Lang J ruled as follows in relation to the EU law on insurance:

> "3. EU Directive 2011/24 ("the Directive") requires each member state to put in place appropriate professional liability insurance, or a similar arrangement, for medical treatment provided on its territory. The Directive was implemented in the UK by the Health Care and Associated Professions (Indemnity Arrangements) Order 2014. It amended the NMC Order to add a new requirement for nurses and midwives to have indemnity arrangements in place.
> 4. Article 12A(1) of the NMC Order provides that a practising registrant must have "an indemnity arrangement which provides appropriate cover". Paragraph (3) defines "appropriate cover" for a nurse or midwife as "cover against liabilities that may be incurred in practising as such which is

> appropriate, having regard to the nature and extent of the risks of practising as such". A registrant who fails to comply with this requirement may be refused registration or removed from the register or may be subject to a charge of impairment of fitness to practise by reason of misconduct."

29. In relation to UK independent midwifery insurance the following historic events were helpfully recorded by Lang J:

> "14. Between 2002 and 30 June 2014 self-employed independent midwives were unable to obtain professional indemnity insurance but had legal expenses insurance.
> 15. In 2003 the NMC Code was amended to recommend that independent midwives should hold indemnity cover, and to require them to advise their clients if they did not have cover in place.
> 16. According to a Department of Health Impact Assessment (dated 1.1.12), in 2005 harm was caused to a mother and baby by an independent midwife, resulting in permanent disability for the child and reconstructive surgery for the mother. The midwife had not informed her client that she had no cover, and she did not have sufficient assets to pay compensation.
> 17. At some stage between 2004 and 2009 (there were conflicting dates in the evidence before me), the Department of Health made a policy decision to introduce a requirement for mandatory indemnity cover for all health professionals. However, concerns were expressed that the market would be unable to offer cover for some groups of self-employed registered healthcare professionals.
> **2009**
> **The Finlay Scott report**
> 18. In 2009 the Secretary of State for Health commissioned an independent review led by Mr Finlay Scott, former Chief Executive of the General Medical Council. It recommended that making insurance or indemnity a condition of registration for health professionals was the most cost-effective and proportionate means of achieving the Government's stated policy objective that all healthcare professionals must have indemnity cover. The review also stated that there were groups of self-employed professionals who could not obtain insurance or indemnity in the market, and an affordable solution should be facilitated for them.
> **2010**
> 19. In December 2010 the Government confirmed its intention to proceed to introduce legislation requiring all registered healthcare professionals to hold mandatory indemnity cover, without

facilitating a solution to the problem identified in the Finlay Scott report.

2011

20. On 9 March 2011 the European Union Directive 2011/24/EU was passed, introducing a mandatory requirement for all EU healthcare professionals to have professional liability insurance or a similar arrangement in place.

The Flaxman report

21. The NMC and the Royal College of Midwives jointly commissioned Flaxman Partners Ltd to prepare a report setting out the feasibility of a model for supporting the continuity of independent midwifery. In September 2011 Flaxman Partners Ltd produced a report called "The Feasibility and Insurability of Independent Midwifery in England", which concluded that independent midwives could only viably secure insurance by becoming an employee of a social enterprise or corporate structure entity regulated by the Care Quality Commission.

2012 – NHSLA "Ten Years of Maternity Claims"

22. In October 2012, the NHS Litigation Authority ("NHSLA") published "Ten Years of Maternity Claims, An Analysis of NHS Litigation Authority Data" (hereinafter referred to as "the NHSLA study"). The Introduction stated:

"Maternity claims account for the highest value, and the second highest number, of claims under the Clinical Negligence Scheme for Trusts (CNST), a risk pooling scheme for NHS organisations managed by the NHSLA. By the end of March 2011, more than 13,000 obstetrics and gynaecology claims, with a total estimated value in excess of £5.2 billion, had been notified to the NHSLA under the CNST since it started in 1995…."

23. The report set out the findings of a study into 5,087 claims on the NHSLA's database between 2000 and 2010. During a similar time period there were 5.5 million births in England, so less than 0.1% of these births had become the subject of an NHS claim. However, the total value of this small percentage of claims was extremely high: £3.1 billion. Of these claims, about 37% did not succeed.

24. The ten most frequent types of claims, out of 21 categories, were those relating to the management of labour (14.05%); caesarean section (13.24%); cerebral palsy (10.65%); perineal trauma (8.66%); antenatal care (7.68%); stillbirth (4.93%); shoulder dystocia (4.91%); CTG interpretation (5.89%); antenatal investigations (7.68%) and retained swabs (3.65%).

25. The ten most expensive types of claim, out of 21 categories, together with the value expressed as a percentage of the total value of the claims, were as follows:

i) Cerebral palsy: £1,263,581,324; 40.52%.
ii) CTG interpretation: £466,393,771; 14.95%.
iii) Management of labour: £424,039,651; 13.60%.
iv) Caesarean section: £216,167,223; 6.93%.
v) Antenatal investigations: £149,986,770; 4.81%.
vi) Antenatal care: £144,811,665; 4.64%.
vii) Shoulder dystocia: £103,520,832; 3.32%.
viii) Uterine rupture: £103,264,627; 3.31%
ix) Operative vaginal delivery: £93,659,223; 3.00%
x) Perineal trauma: £31,202,836; 1.00%

26. The NHSLA study helpfully indicated the nature of the risks, and the number and size of claims, but as it did not distinguish between negligence on the part of midwives and other medical professionals, it did not provide evidence of claims against midwives as a group. Moreover it was based on NHS hospital maternity care, so it included surgical procedures, interventions such as forceps, drugs to induce labour, and CTG monitoring which independent midwives, who only attended home births, and favoured low-intervention care, would not be involved in.

2013

27. On 22 February 2013 the Department of Health issued a consultation document on the proposed UK legislation.

28. At this time, IMUK decided to pursue a self-insure solution. It proposed setting up a protected cell named "Lucina" within a Protected Cell Company named Windward Insurance PCC Ltd, to be registered in Guernsey. In 2013, IMUK made an application to the Guernsey regulator for a licence to form the Lucina captive cell."

…

"32. On 17 July 2014 the NMC Order was amended to introduce the new article 12A requiring registrants to have an indemnity arrangement which provided appropriate cover.

NMC Guidance 2014

33. In July 2014 the NMC issued a document entitled "Professional Indemnity arrangement: A new requirement for registration". It explained that whilst the majority of registrants would be covered by their employers' schemes, self-employed registrants would need to obtain their own cover, either as part of a membership of a professional body or from a commercial provider. It was made clear that registrants would have to make a declaration that they had obtained cover, and they could be subject to compliance checks. In

> answer to the question "what is appropriate cover?" it stated as follows:
> "Appropriate cover is an indemnity arrangement which is appropriate to your role and scope of practice and its risks. The cover must be intended to be sufficient to meet an award of damages if a successful claim is made against you.
> Determining what appropriate cover is for you will be influenced by:
> - what your job involves and where you work;
> - who you provide care to and the level of care you provide;
> - the risks involved with your practice.
> We are unable to advise you about the level of cover that you need. We consider that you are in the best position to determine, with your indemnity provider, what level of cover is appropriate for your practice. You should seek advice as appropriate from your professional body, trade union or insurer to inform your decision….
> If you have made your own professional indemnity arrangements, you should make sure that you understand how your cover will work. For example, most indemnity insurance will be offered on a 'claims-made' basis, this means that the cover would need to be in place both when the event causing the claim occurred and when the claim was made (which may be years later). This also includes understanding any requirements to disclose relevant information to your indemnity provider which would influence a provider's decision whether or not to offer cover."
> 34. In July 2014, IMUK took out an insurance policy with Elite Insurance ("Elite") on behalf of its members which provided cover of only £400,000 per claim."

30. So it is clear that Government policy guided the requirement for insurance for midwives. In relation to whether the Lucina Insurance was sufficient the NMC registrar had concluded that:

> "54 Having considered all of the information carefully, I have concluded that Lucina does not have available to it sufficient financial resource to meet its liabilities, having regard to the nature and extent of the risks. This was a conclusion which I had reached previously on a provisional basis on 4 August 2016 on the information available to me at the time. Since that date, despite extensive representations from Lucina and IMUK, I have not received the assurance I needed to conclude that the Lucina scheme provides appropriate cover to IMUK members having regard to the nature and extent of the risks."

31. The claimants' judicial review failed before Lang J. because the insurance which they had arranged was not sufficient.

32. In my judgment it is clear from *Beety*, the NMC Order and Rules and as a matter of common sense and logic that a midwife providing maternity and/or birthing services without adequate insurance is not regarded as appropriate for the protection of the public due to the risks inherent in childbirth to mothers and babies. Such activity will likely lead to the uninsured midwife being struck off the NMC register.

Evidence

33. The evidence before this Court was in writing and contained in the bundles set out above. I was informed that all of the documents before the FTPP were before me.

34. Despite the Appellant asserting, at the start of the appeal, that there were no new documents in the appeal bundles he had provided (which were not before the FTPP) many new documents and witnesses statement were in fact in the Appellant's bundles.

35. After the Court had explained the procedure and rules to the Appellant he sought to apply for permission to rely on new evidence. This application was made during the first morning of the hearing. Most of the new evidence was contained in bundle 5 which consisted of 13 separate documents which were variously:

- the Appellant's civil claim against the NMC;
- the Appellant's claim against the Ministry of Justice and Minister of Health;
- the Appellant's claim against SOMEK, the company for whom the NMC's expert witness, Emma Twine worked;
- questions drafted by the Appellant in September 2020 about his interim suspension sent to the chief executive of the NMC;
- a claim by the Appellant against Frimley Park Hospital NHS Trust;
- a document drafted by Jacqueline Dunkley Bent containing asserted human rights failings in relation to NHS England;
- a claim by the Appellant against the Solicitors Regulatory Authority;
- a commentary by a group called Human Rights Action of which the Appellant is a senior member about a UNCEDAW draft shadow report in relation to international midwifery;
- a claim by the Appellant or the Human Rights Action group against the Professional Standards Authority;
- a document drafted by the Appellant addressed to the NMC alleging that the NMC regularly fails to meet it overarching commitments;
- a claim by a Amira Cermagic against the Government of Bosnia in the European Court of Human Rights;

- documentation relating to the adjourned hearing in November 2021 of the Appellant's appeal listed before Lang J in which the Appellant raised matters (denied by Lang J) which led to her recusing herself from this appeal and it being adjourned.

36. I considered submissions on the admission of those documents and for the reasons given in an extemporary judgment refused to admit those in evidence. All or most of them could have been produced at the FTPP hearing and would have been admitted if they were relevant. I did not consider any of them were relevant. They did not impinge on the facts of the case, or on the issues in the appeal. The Appellant failed to satisfy the 3 limb test set out in *Ladd v Marshall* [1954] 1 W.L.R. 1489, for this court to admit fresh evidence on appeal which had not been put before the FTPP. No proper explanation was given as to why those documents were not produced earlier and no reasonable or substantive explanation was given as to the relevance of those documents to any issue in the case. All that they proved was that the Appellant is involved in a substantial number of claims which he has brought against a wide range of government and regulatory institutions none of which have produced a judgment in his favour to date.

37. In addition, in Bundle 5 was one document which I did grant permission to be admitted into evidence. It was an "Insight Document" drafted by the Appellant relevant to sanction. He had put no such document before the FTPP. Like (nearly) all of the Appellant's documents it was undated and did not bear his address or signature. I set it out below:

> **"Insight**
> I understand there is no professional identity insurance available in France
> I understand that a woman has bodily autonomy including the right to make choices in childbirth such as where she births how she births who she births with etc.
> I understand that women are free to choose to birth outside the hospital system.
> I understand that we owe a duty of care to our neighbour and this duty of care is increased in healthcare relationships such as Midwifery.
> I understand that I need proper training and experience in the areas of work that I find myself engaged such as community-based maternity care and home birth
> I have significant ongoing training and experience in this area.
> **Paul Golden**
> Registrant Nurse / Midwife
> Appellant"

38. I have taken this insight into account when considering the appeal against sanction below.

39. In addition the Appellant sought to put into evidence witness statements from the following 10 witnesses:

- Deborah Hughes, admitted into evidence.
- Annabelle Bryant, admitted into evidence.
- Kathryn Weymouth, admitted into evidence.
- Nyree Wright, admitted into evidence.
- Suzanne Dorfler, admitted into evidence.
- Nandu Noll, admitted into evidence.
- Sandi Blankenship, admitted into evidence.

_____

- Laura Gilmore, not relevant.
- Xandra Samson, not relevant.
- Nita Hansen, not relevant.

40. Many of the statements bore no signature, had no address and some had no date. After hearing submissions I provided an extemporary judgment admitting in evidence the witness statements indicated above because those witness statements went to potentially relevant factual matters, including the issue of access to the online final hearing and events on 24th September 2019. I did so exceptionally, without intending to create any precedent for other self-represented appellants, so as to permit this Appellant his broadest opportunity to substantiate his appeal. Some of those witness statements were available or should have been available at the time of the final hearing and two of them had in fact been sent to the NMC before the final hearing as part of the Appellant's evidence in relation to his interim suspension order and the appeal thereof. But none was listed in a final hearing witness list (for he provided none) or identified by the Appellant for the final FTPP hearing.

41. I also gave permission for the admission into evidence of some other documents drafted by the Appellant: (1) criticising the NMC's expert; (2) a timeline of events in the summer of 2019 and (3) a "statement by the Defendant re complainant" (which in effect were the Appellant's undated, unsigned evidence of events with no statement of truth). Some of the documents were not objected to by the NMC, those were admitted into evidence too; others: a statement to a Parliamentary Select Committee by Caroline Flint and a document from "NMC Watch" were not relevant to the issues and were not admitted into evidence.

42. During the Appellant's submissions it became apparent that the Appellant was trying to give further evidence as to the facts of the events in the summer of 2019.

The Court explained that if the Appellant was intending to give evidence he would need to apply to put in new evidence. The Appellant made the application orally and it was opposed by the NMC. In summary, for the reasons explained in an extemporary judgement, I refused the application. The NMC opposed the application on various bases which I accepted. Firstly, on the basis that the Appellant had not put in a witness statement before the FTPP. Secondly, the Appellant had not given the evidence live before the FTPP. Thirdly, the Appellant had not put any witness statement of his evidence in the appeal bundle. Fourthly, if permission was to be granted a full witness statement in writing, dated and signed with a statement of truth would be needed and none had been provided. Fifthly, cross examination would need to take place and that might require an adjournment for preparation and in any event would elongate the hearing beyond the two days allowed. Sixthly, on the basis that it would set a bad precedent for registrants in future who refused to provide evidence before the FTPP. I considered that, taking into account the whole of the circumstances in relation to the Appellant's behaviour during the investigation, leading up to the final hearing, during the final hearing and since and for the reasons set out in *Ladd v Marshall* it would not be appropriate to allow the Appellant to give live evidence at the appeal hearing where he had refused to give evidence before. He had been given ample opportunity to give his evidence before and during the final hearing and he had refused to do so. However, I did admit in evidence the various documents containing his written factual assertions which were in his appeal bundles and so had been available to the NMC in preparation for the appeal.

The Tribunal's Judgment

43. I set out below the decisions of the FTPP interposed with my findings of fact. My findings relate to the chronology of the events leading up to the final hearing and the events surrounding it. I make the findings on the balance of probabilities.

Events leading up to the complaint

The contract

44. In a WhatsApp message sent in March 2019 by M to Kathryn Weymouth (KW), (one of the witnesses relied on by the Appellant in this appeal) M asked KW whether she knew of an experienced independent midwife to assist with her birth. She said that she was due on the 9th of September 2019 and she mentioned the background which was that KW was attending the birth, in France, of Colette Corcoran's child in July of 2019, presumably as an independent midwife. Colette Corcoran was M's friend and neighbour. KW suggested that M should contact the Appellant. After some correspondence the Appellant sent his form of contract. It was signed and dated 24th May 2019 and required the Appellant to carry out regular maternity visits and to fill out maternity notes which M would keep for her pregnancy. There was a provision to record details of M's local doctor and backup hospital contacts, her blood group and medical history. The contract provided for antenatal visits and birth preparations and the birth and post-natal visits focused on

recovery and breast feeding. The contract stated that they would hold a Skype meeting once a week until 42 weeks and twice a week past 42 weeks. The contract provided that M should arrange for appropriate backup care and, if M could not do so, then the Appellant might be able to arrange another independent midwife to attend if required. The Appellant stated that he might introduce a "doula" or therapist. The Appellant wrote that, should M go into labour before he arrived, suitable backup plans would be made and he would still provide valuable post-natal care. The Appellant asserted he had "not missed a birth yet" but could not guarantee he would arrive on time. The contract expressly stated that the Appellant was registered with the NMC but only had professional insurance in the UK. The contract provided for a charge of £3,000, or £1,000 pounds pw with a minimum of three weeks, which covered all midwifery care and visits, from the pre booking visit until discharge. It was stated that the discharge date might vary but would usually be when the baby had reached two to three weeks of age. M paid the £3,000 pounds. It will be clear from this summary that the date for the end of the Appellant's duties was contradictory. Either it was 3 weeks work or it was until the baby reaching 2-3 weeks old.

The summer of 2019 in France

45. The Appellant arrived in France on the 31st of August 2019. He was housed in a caravan owned by Miss Corcoran close to M's house.

46. The following account comes from the Appellant's unsigned, undated Timeline Diary produced for the Appeal but not put before the FTPP. On the 1st of September according to the Appellant they talked about the pregnancy and birth options. The Appellant asserted that M had told him that she had split up with her boyfriend and the pregnancy was unplanned. On the 3rd of September the Appellant and M had a home visit and walked and talked. On the 5th of September M and the Appellant walked around the village and discussed her past family relationships and the Appellant asserted he advised M to contact a local midwife (Elise Fougeras) to discuss local ultrasound facilities. The Appellant asserted that he went to meet Elise Fougeras at her clinic but she refused to accept any pregnant woman who was not in the French system with a maternity care number and also booked with a doctor. On the 8th of September the Appellant asserted that he met with a midwife in Gueret but she would not assist M either. On the 9th of September the Appellant carried out a home visit and discussed options and potential complications. He went to get pharmacy supplies. On the 11th of September he went to Limoges hospital to discuss what resources were available there. On the 12th of September he met a midwife in St Yrieixla Perch for local information. Then he examined M at home and considered that labour was not imminent and they agreed that he could go to the seaside the next day. On the 12th of September he went to the seaside. No note is made as to what happened between the 13th and the 16th of September but on the 17th of September the Appellant asserts that M asked him to leave and to return when she started labour. The Appellant asserted this was a surprise and that they

discussed the implications, risks and possibilities. I bear in mind that all this was not in evidence before the FTPP and not in any signed witness statement with a statement of truth and that the Appellant was not tested on these assertions by cross examination.

47. M's evidence was contained in her written complaint dated October 2019, her later witness statement to the NMC dated 15th September 2020, her second witness statement and her live evidence. I give due deference to the FTPP who heard and saw her evidence. M's written documents were signed. M explained she wanted a natural home birth and after KW had recommended the Appellant she contacted him to provide that for her. M stated that the Appellant informed her that he was not insured. She decided that if there were complications she would not sue him. She signed the contract. This was her first pregnancy and she chose not to have any scans of the baby at all. She calculated she was due on the 9th of September 2019. She asserted in her first witness statement that after the Appellant arrived she informed him that she had felt a "little gush of water". She complained he did not really acknowledge this and advised the baby was still high and the birth was not imminent. She complained that the Appellant completed no documentation whilst he was in France. She asserted that the Appellant told her that he would not complete the documentation because he was not insured. He printed off a maternity record booklet and gave it to her but never wrote in it. It was blank and was put in evidence as her exhibit. He carried out external examinations and gave advice to her. She asserted that the Appellant suggested he should leave and return when the pregnancy was progressing. Then she stated that he changed his mind and spent a few days away at the coast 3-4 hours drive from her house. Then on the 15th of September they both agreed he should go home which she thought was to London but turned out to be Slovenia. The Appellant left his medical kit and some clothes in the caravan where he had been sleeping and he left Oxytocin in her fridge. M stated that the Appellant had been in contact with other midwifes in France and had passed on their contact details to her. During correspondence between the 17th of September and the 8th of October 2019 and the Appellant gave her the details of Elise Fougeras, a local midwife.

48. In her supplementary witness statement M asserted that during his stay in France M had sent the Appellant a text writing that she had felt "a little gush of water" on a date she could not remember. After a number of days, the number of which she could not remember, he had examined her. He checked her heart rate and felt the position of the baby exteriorly. She could not recall if he suggested any other examination. This witness statement is rather unsatisfactory in my judgement and lacked detail or specificity. It also contradicted her earlier witness statement which included the assertion that the "gush" conversation was at or close to his arrival.

49. The pregnancy record or log was exhibited before the FTPP and is a substantial document in a familiar format containing 25 pages, none of which had been filled in.

50. Without descending into the detail, there was correspondence between the 17th and 24th of September on which date the Appellant was in Austria, lecturing when he received communications from M that she was experiencing contractions and pain. The Appellant's evidence about this date is backed up by one of his witnesses. He decided this was a call by M to assist her and so he made plans to travel to M. He was driven to the local train station and travelled to Venice where he had bought a ticket to fly to France, but during that train journey further communications from M led to him cancelling the flight because the contractions had stopped. This event on the 24th of September was not dealt with in the two witness statements to the fitness to practise panel by M. However, it was covered in the emails put before the panel.

51. WhatsApp messages and e-mail messages were later exchanged between M and the Appellant between the 3rd of October and the 8th of October 2019. It is clear from these messages, disclosed by M, that she must have had a communication or conversation with the Appellant about sweeping her membranes because she recited that in a WhatsApp message to KW. KW sent to M parts of the NICE Guidelines on induction of labour and on what to do after the due date has been passed and advised M to discuss these with the Appellant.

52. Whilst the emails in the bundles are not in chronological order and are clearly not complete it is apparent that by October the 4th the relationship had soured. At 6:26 pm that evening the Appellant wrote about M's recent messages advising that the choices were hers and she had to appraise the benefits and risks in relation to blood tests, baby scans and booking a midwife. He recited that their arrangement had been for three weeks work and that it had ended. He recited that he had been on call for three further weeks since he had left France. He recited the events on the 24th of September in which he asserted that M had asked him to fly back to France and he had booked travel from Venice and that she had cancelled that trip which had cost him well over 1,000 (euros I assume). He wanted her to make her choices and signed off with the assertion that he would help M with whatever he could. That evening M wrote to the Appellant at 9.56 pm. She raised the point that the contract stated they would meet weekly until 42 weeks and then twice weekly thereafter. In that e-mail, (in contradiction to her witness statement) M asserted that she had asked the Appellant to leave France. She understood that they had agreed he would return for the birth. She accepted that she had contacted him on the 24th of September but asserted she had never *asked* him to return. She accepted she had agreed to pay for transport. She raised the presence of his clothes and a bag of his equipment in the caravan and asserted that she felt vulnerable without support and she mentioned that on the 4th of October she had lost her "mucus plug" and stated

"today I messaged you to inform you I had lost my mucus plug, as we discussed I would should I lose my mucus or my waters break and you do not respond the whole day. As a healthcare provider, you do have a duty of care for your patient". In my judgment this is very relevant evidence when we turn to the findings of the FTPP in relation to the discussion allegedly had the "gush", about her waters breaking, earlier when the Appellant had been in France. The Appellant responded that evening interposing his comments with each paragraph from M's e-mail. He pointed out that M only wanted a three-week contract. That her gestation date (9.9.2019) appeared to be incorrect. That on the 24th of September M had said she was having regular painful contractions and that labour had started, therefore it was reasonable for him to assume she wanted him to arrive and so he had booked transport. That M had asked him earlier to leave France. He could only return in future if it was possible depending on his other commitments. Lastly, he pointed out that the birth had not happened in the three-week booking period M had hired him for. He advised that she could choose to find another midwife or something else. He pointed out that the best baby well-being assessments would be: assessment of the baby's movement, the heart rate and by scanning. He stated that he had not been able to find another birth midwife who was available and asked whether M had contacted Elise Fougeras. Finally the Appellant advised M to see a local midwife.

53. Further emails were sent on the 5th and the 8th of October. On Tuesday the 8th of October, after M had demanded a refund of £1,500, the Appellant wrote at 12:26 PM *"I trust that with time you accept the realities of time and distance and that the agreement ended which mean that I am not your midwife."*

54. Perhaps not unrelated to these emails is the fact that on the 8th of October M went for a scan with the French health services and was advised that she needed induction of labour. This took place at a hospital on the 10th of October and the birth was successful.

55. On the 28th of October 2019 M completed a patient complaint form for the NMC. The complaints were variously set out. The first was that the Appellant made no medical notes. The second was that he had left oxytocin in her fridge. The third was that he was not insured. The fourth was that he did not return and that despite her informing him of various events he did not advise her in relation to how to induce labour. She also complained that he terminated the contract before she gave birth. In section 34 of the complaint form she set out in more detail what her complaints were but it is noteworthy that this longer section does not include any assertion that her waters broke whilst the Appellant was in France or that she told him, that she had a "gush". This was her most contemporaneous account, as a result, I consider that it should have been considered her most reliable account by the FTPP.

From the complaint to the hearing

56. The charges which the NMC laid against the Appellant were:

> "That you, a registered nurse and midwife
> 1. Did not complete a full risk assessment during Patient A's initial appointment with you or, in the alternative, did not make any record of the risk assessment you had performed in Patient A's notes.
> 2. Following Patient A reporting a suspected rupture of membranes to you:
>
> a. did not record the suspected rupture of membranes in Patient A's notes.
>
> b. did not advise Patient A that she should allow you to examine her to confirm whether her membranes had ruptured or, in the alternative, did not make any record of your advice to Patient A and her response in Patient A's notes
>
> 3. Did not provide information to Patient A concerning:
>
> a. the risks that would arise if her pregnancy lasted longer than 42 weeks.
>
> b. the types of clinical intervention which she should consider and which you would recommend if her pregnancy lasted longer than 42 weeks or, in the alternative, did not make any record of the information you provided and the discussion you had in Patient A's notes.
>
> 4. In addition to the matters set out in charges 1-3 above, did not complete any records in respect of the care you provided to Patient A.
> 5. Did not store Oxytocin appropriately in that you stored it in a communal fridge and took no steps to secure it.
> 6. Did not attempt to handover Patient A's care to another midwife and/or obstetrician when it would have been appropriate to do so in view of your decision that you would no longer act as her midwife and the late stage of her pregnancy.
> 7. Delegated Patient A's care to Person A when it was inappropriate to do so in view of her not being a healthcare professional.
> 8. Practised midwifery in France without requesting leave to provide midwifery services from the French Order of Midwives.
> 9. Practised midwifery in France without having in place appropriate insurance.
> 10. In practising without leave from the French Order of Midwives and/or without insurance you acted without integrity in that you knew you were not entitled to practise midwifery in France but did so anyway.

> 11. In failing to keep records of Patient A's care you acted without integrity in that by doing so you intended to minimise the risk of your unregistered and/or uninsured practice coming to the attention of the French authorities.
>
> AND in light of the above, your fitness to practise is impaired by reason of your misconduct."

57. Between the laying of the complaint and August of 2021 an interim suspension order was made suspending the Appellant's ability to practise as an NMC, UK registered midwife. He appealed to the High Court and was unsuccessful save as to a reduction in the length of the suspension. He appealed to the Court of Appeal and that appeal was not granted permission.

58. In August 2021 the final form charges were provided to the Appellant at the email address he required the NMC to use. The Appellant was invited to fill in a case management form. The form invited him to set out whether the charges were admitted or denied, which facts were admitted or denied and which witnesses he would rely on in his defence and to provide his evidence. Information in relation to the setting of the dates of the final hearing was also requested. The Appellant chose not to fill in that form and did not return it despite subsequent communications at the start of September in which he made various complaints and in response to which the NMC repeated the request for the information they had sought in the form.

59. In December 2021 the Appellant was given notification of the dates for the final hearing which was to start on the 1st of April 2022 and to end on the 20th of April 2022. In correspondence which took place between then and the end of March 2022 the Appellant was reminded on various separate occasions of the dates of the final hearing. The Appellant was asked to attend a pre-hearing case management conference chaired by an NMC listing officer to discuss legal issues, hearing bundles, the evidence to be called and to determine whether directions were needed. He refused to engage. In a witness statement provided by Sylvia Opoku to the panel, proof of service was evidenced. The letter of the 6th of December 2021 to the Appellant was exhibited which set out the meeting details and the online link and a phone number to call to attend the hearing. It set out the charges, gave advice on attending the hearing remotely and warned that the hearing would go ahead without the Appellant should he choose not to attend. He was reminded of the need to refer to the bundle of evidence provided to him on the 6th of May 2021 which included the NMC witness statements and expert's report and the documents for the hearing. He was invited to give written or other evidence to the panel and to send his bundle to the NMC. He was reminded of his right to call witnesses and to cross examine witnesses called by the NMC. He was asked to fill in a form in response to the notice of hearing which was admirably clear. He refused to do so. On the 14th of

February 2022 he was reminded of the dates of the hearing and invited to the pre-hearing conference on either the 24th of February or the 2nd of March. He responded to that by providing a document which was both obstructive and disruptive but did not answer the questions asked. Then on the 1st of March he again emailed the NMC copying in the chief executive and setting out a list of complaints and criticisms which were both obstructive and disruptive and he failed to provide his own witness statement or witness statements from his witnesses or any documentary bundle. Instead he required to call the senior management of the NMC as witnesses at the final hearing. He relied on the war in the Ukraine and broad allegations made against the NMC accusing them of having case managers who were petulant, insulting and obstructive. I will not set out the detail here save to say that it was a particularly unhelpful communication. The NMC staff responded with restraint and professionalism reminding him of the need to take part in the process. Reminding him that the case management form had been sent to him on the 23rd of August 2021 and that in further correspondence on the 2nd and 3rd of September 2021 he had again been asked to complete it and provide his evidence and information and re-inviting him to attend a pre-hearing case conference to manage the final hearing. His response, again copied to the chief executive of the NMC, was obstructive and disruptive. He did not provide a list of the witnesses he wanted to rely on nor a witness statement from himself nor any documents. On the 18th of March the NMC once again reminded the Appellant of the dates of the hearing and of the notifications he had been given and informed the Appellant again that the NMC were relying on all of the witnesses whose statements had been provided to him. They also asked what adjustments he needed in relation to the alleged disabilities that he had set out in his various communications which were only of a very general nature. On the 31st of March, the day before the hearing, the Appellant sent another communication, this time advising the panel in a quasi-legal manner on how they should proceed and copied it again to the CEO of the NMC. Once again he failed to take the opportunity to put in a witness statement from himself or his other witnesses or a documents bundle. He questioned whether there was a final hearing at all and stated that it was unclear to him whether there was. On the 31st of March 2022, by way of response, the NMC once again set out the charges and that they were calling witnesses at the final hearing the next day and informed him of the composition of the panel and invited him to set out what disabilities he was suffering so that adjustments could be made for him.

The final hearing before the FTPP

60. The final hearing commenced online on Friday 1st April 2022 and the second day was Monday 4th April 2022. The events developed as set out in the FTPP's decision document.

61. On the 20th of April 2022 the FTPP (the Panel) provided its decision (later released in writing to the Appellant and dated 22.4.2022). The panel consisted of three members. John Vellacott was the lay chair, Linda Tapson was the registrant

member and Seamus MaGee was another lay member. They were assisted by Oliver Wise, the legal assessor. There was an observer called Sarah McLuckie, the hearing coordinator was Vicki Green and the case presenter for the NMC was Scott Smith.

Absence

62. The panel noted that before the final hearing the Appellant had been actively involved in communication however he did not attend the pre-hearing meeting, despite being invited by e-mail. He was given notice of the dates of the final hearing by e-mail on 6 December 2021. The Appellant had attended at previous interlocutory hearings by video. In March of 2022 the Appellant had communicated by e-mail in relation to the preliminary meetings and had made requests for lists of NMC witnesses and had stated that he wanted to call the chief executive of the NMC and the case handlers but had not himself provided a list of witnesses of fact or expert witnesses. The panel noted the Appellant had been sent a case management form on the 23rd of August 2021 but had not filled it in or returned it. The panel noted that reminder emails of the date of the hearing had been sent to the Appellant on 14.2.2022 and 1.3.2022 and 10.3.2022. The panel considered its discretion under Rule 21 taking into account that the three in person NMC witnesses to be called were ready to proceed and took into account the public interest in regulatory proceedings being dealt with expeditiously. The panel took into account that care would need to be taken because the witnesses would not be cross examined in the absence of the Appellant should they exercise their discretion to proceed. They decided to proceed.

Hearsay evidence received

63. The panel decided to admit, as hearsay evidence under Rule 31, the statement of Miss Corcoran who was not prepared to give evidence. The panel took into account the ruling in *Thorneycroft v NMC* and that the Appellant had been notified that this witness would not attend but had not responded to that notification. The panel also noted that the substance of the evidence of this witness was supported by an e-mail from the Appellant to the witness setting out the evidence about one allegation which the witness made in her witness statement.

The hearing

64. The hearing preceded on the 1st of April but evidence was not called until Monday 4th April and the Appellant was not present. He did not call in either. Over the weekend 2/3rd April 2022 he had emailed asking why there was a final hearing and when it was; asking for reasonable adjustments due to the war in Ukraine but not stating what the adjustments were; asking when he was required to attend; suggesting the hearing only needed to be three days long and suggesting the hearing was a breach of his human rights under article three of you UNCHR (sic). The Appellant suggested that the 12 day hearing was disproportionately long and therefore cruel, inhuman and degrading punishment for him. The document also suggested there were documents attached to it for the attention of the panel and

asked for a transcript and provided the following: "the Ockendon Report" and "the Kirkup report" and the "UNCEDAW reports and shadow reports". Copies of those reports were not provided by him.

65. The hearing went ahead and on the next day (5th April) the Appellant emailed the NMC chief executive and other senior staff of the NMC alleging that the hearing was being held "in secret" with "no notice" to the Appellant or to the public and that the prosecutor was conducting the case in an aggressive and harmful way. The Appellant alleged that his position included "vulnerability, disability, impecuniosity, discrimination and war". The Appellant required the CEO to review the case and his representations and to respond by return.

66. As set out in the decision of the FTPP this e-mail was treated as an application to adjourn. I have read the reasoning of the panel and consider that it was lawful, logical and sensible in the circumstances to refuse to adjourn.

The experts

67. As set out in the panel's decision the panel heard evidence from M, an expert witness named Emma Twine and an expert witness on French midwifery called Jean Marc Delahaye. They also permitted the written witness statement of Colette Corcoran to be put in as hearsay evidence.

68. The FTPP was provided with an expert report from Emma Twine a midwife dated 4.6.2021. She advised that midwives were required to follow the NICE Guidelines when caring for a pregnant mother. She opined that the Appellant's initial risk assessment was inadequate and unrecorded. She accepted M's account of the "gush" of waters as occurring at their first meeting on 31.8.2019 (although the first witness statement did not state that date) and ignored the absence of such complaint in the more contemporaneous written NMC complaint in October 2019. For the reasons set out in this judgment I have found M's evidence on that complaint to be vague, contradictory and unreliable. Miss Twine advised that the Appellant failed to advise M adequately in relation to going beyond term and the risks thereof and the methods available to ameliorate the risks. Miss Twine advised that the Appellant's duty on terminating his care for M was to handover to another professional unless M had declined care and requested to be discharged. She did so without reference to the terms of the contract, which as I have set out above, were contradictory in relation to when the Appellant's care for M would end. Miss Twine advised that by early October M was 42-44 weeks pregnant and so was at a high risk. She needed increased monitoring. She needed referral to an obstetrician. She considered that the Appellant failed to refer M to and to hand M over to another professional when he terminated the contract. Miss Twine advised that the Appellant's advice to M and Miss Corcoran that the latter could attend the birth to deliver the baby as his delegate was a breach of the NMC Code. Miss Twine advised that the NMC Code required midwives to secure Oxytocin securely. She advised

that the Code required midwives to record all of their interactions with patients in writing.

69. In the Appellant's written rebuttal, provided to the appeal Court but not to the FTPP, the Appellant criticised Miss Twine for having a conflict of interest for having worked at a hospital where he worked between the 1980s and an unknown date. He asserted he had supported some criminal complaints made against hospital staff including midwives in those years. I do not find that asserted fact to be sufficient to raise a conflict of interest. He complained that Miss Twine did not consider his rebuttal documentation, but he had not provided any witness statement to the NMC for her to be able to do so. He asserted that M terminated their contract when M asked him to leave France. That assertion is not evidenced by the communications between the Appellant and M thereafter – for instance his abortive journey from Austria to France via Venice on 24.9.2019. The Appellant asserted that the NICE Guidelines had "no jurisdiction" outside the UK. I do not accept that assertion. Standards are standards, they do not stop in the middle of the English Channel. The Appellant asserted that he had made full written notes in her antenatal notes book, yet as set out above these were completely blank and the Appellant did not produce even his allegedly reconstructed notes either for the FTPP or in the appeal. He asserted that he advised M to get scanning and FHR monitoring and that he noted that advice, but no such note was in evidence. He asserted that he was in touch with local midwives and maternity resources but M refused to engage with them. This assertion was not evidence by any clinical records or in a witness statement from the Appellant. However, the communications after he left France do contain references to recommendations he made to M to contact "Elise" (Elise Fougeras), a local midwife who M and the Appellant both stated had refused to get involved because the Appellant had generated a bad experience with her previously. The Appellant asserted that because Miss Corcoran's evidence was hearsay it should not have been considered by Miss Twine. He criticised the NMC case managers and asserted that they were not properly trained or supervised.

70. The Appellant pointed out that M had not complained of spontaneous rupture of her membranes whilst he was in France. He asserted they did discuss a "show" and he advised obtaining an ultrasound. He also advised her to see the local midwife in the written communications before the FTPP when she raised having a mucus plug discharge.

71. In summary I do not find any of the Appellant's criticisms of Miss Twine's evidence either persuasive or grounded in evidence, save for one which I shall consider below.

The charges

72. The panel found charge one proven to the effect that the Appellant failed to carry out an adequate risk assessment of M at the start of his care for her in France and had failed to record what he did.

73. The panel found charged 2a proven, namely that the Appellant should have recorded any complaint of a "gush of water" in the medical notes and examined M for ruptured membranes. That should have included an internal examination. In relation to this charge on all the evidence that I have read and taking into account the evidence given to the panel I do not consider that there was sufficient or clear evidence to justify the panel's decision. It is clear in my judgment, and I find as a fact, not only from the two statements from M, but also from the statements made in messaging and emails after the Appellant left France, that there was no assertion that M told the Appellant whilst he was in France that she had suffered a "gush of water" which could have indicated that her waters had broken. If the NMC were to be able to find that proven they would have been helped by seeing the medical notes taken of the scan on the 8th of October and the hospital treatment on the 10th of October when M gave birth to show that there was a clear diagnosis that her waters had long since broken and that she had no amniotic fluid at the date of the scan. There was no such evidence. Also in M's witness statements there was contradictory evidence. In paragraph 6 of the first statement, M asserted no date for the comment but suggested that the comment was made when the Appellant arrived on 31st August 2019. This is to be contrasted with the fact that there was no evidence to that effect in her complaint written 11 months earlier to the NMC. Instead, in that complaint, M asserted that the Appellant and she discussed waters breaking and a bloody show and he asked her to inform him if those occurred and then he left France. This substantially undermines what she later wrote in her witness statement. In the transcript this issue was not opened up at the final hearing. On this evidence in my judgment it was not right to find charge 2a proven on the balance of probabilities. It is noteworthy that the panel found charge, 2b: failure to carry out an internal examination, not proven.

74. As to charges 3a and 3b the panel found both were proven on strong evidence from the expert and I have found nothing to cause me to disagree with that finding.

75. On charge 4, the lack of records, the panel found the charge proven. In relation to this charge the Appellant's approach in the appeal was bizarre. The Appellant asserted that he had completed the pregnancy records in full before he left France and in effect was asserting fraud or dishonesty by M in that she somehow obtained a blank set of notes and hid or failed to produce his notes both to the hospital and the FTPP. He went on to assert in submissions that he had reconstructed his maternity records and could make them available to the court on day two of the appeal hearing. At the very end of day two of the hearing the Appellant stated that he had stored the reconstructed medical records at a property in England in an unmarked box and had not been able to find them.

76. The panel found charge 5 proven, namely the storage of oxytocin in an insecure place. The Appellant's response to this was that it was wholly proper to store the Oxytocin in M's fridge. He was a midwife, a travelling, independent midwife. He accepted that Oxytocin could be stored at room temperature but he asserted that it was a very hot summer and that it would not have been safe to store the Oxytocin out of the fridge. I might have found that argument attractive during the period when he was in France if he had taken precautions to secure the Oxytocin in the fridge inside some form of locked box but the expert advised it was unacceptable that he left the Oxytocin unprotected in M's fridge after he departed from France. When I asked the Appellant about the risk of a child, for instance of age 4, going into the fridge and deciding that the bottle of medicine looked inviting, he had no substantive response to that risk. Thus I have found no reason to query the finding of the panel on this charge.

77. In relation to charge 6 and the failure in the handover of care, the panel found it proven. In particular the panel relied on the e-mail of the 8th of October when the Appellant washed his hands of M stating the agreement was at an end and that he was not her midwife. For a while I was troubled by this because the contract was for three weeks work and M had not agreed to pay more than £3,000 pounds. When the Appellant left France he had completed 17 days of work so there was a hangover of only three days of work. This created difficulties in the relationship and it could be said that the drafting of his own contract was vague in relation to this element, which was his fault. On the other hand the contract did make it clear that he would be present before during and after the birth up until the child reaching the age of two or three weeks, either physically present or on call, therefore I do not consider it would be appropriate for me to interfere with the panel's finding on a purely contractual basis. In addition, of course, this is a matter particularly within the purview of professional experience and I should be and am wary of challenging such matters.

78. The panel found charge 7, delegating to a non-professional, proven and an e-mail communication between the Appellant and M was prayed in support of that charge as well as the hearsay evidence of Miss Corcoran. The evidence supported that finding. The Appellant should not have suggested that Miss Corcoran could have taken his place as the midwife at M's birth.

79. The panel found charges 8 and 9 proven. Those charges related to the lack of registration in France and the lack of insurance. Those findings are not challenged by the Appellant on appeal despite his complaints that it was a bureaucratic process in France and that it was impossible to get insurance for practice in France.

80. Charges 10 and 11 relating to lack of integrity were found proven by the panel and I see no reason to overturn those charges in the light of all that is set out above.

81. The panel went on to consider the Appellant's fitness to practise and in my judgment the reasoning given for their findings is sound and well evidenced. In particular the focus on maintaining and declaring proper professional standards for the protection of the public and to avoid bringing the profession into disrepute was carefully considered. The terms of the Code were carefully considered and set out. The relevant test in the case law was set out. The panel considered whether the breaches were remediable but in view of the Appellant's attitude, failure to leave an audit trail, his intentionality about his unlawful activity, his lack of insight and his failure to cooperate with the NMC and the panel, I consider that the panel were right to reach the conclusion that they did.

82. At the end of the panel hearing the Appellant engaged online on the 19th of April 2022 having just sent bundles of witness statements and documents to the panel which the panel did take into account despite the Appellant's failure to do so earlier. The 19th of April 2022 requires some consideration. The Appellant provided to the appeal Court various witness statements from colleagues who had attempted to join the panel's hearing on that date and asserted that they could not do so. However, the panel decision makes it clear that because the Appellant had very recently sent a large bundle of documentation to the panel it retired into private session for a number of hours that morning to read it. Therefore, there was no online access for anybody during their retirement. The Appellant was informed of this. Communications were provided to the Appellant by the NMC informing him that the hearing would re-start again at midday and despite being so informed he did not again attempt to join the hearing. Therefore, I accept the evidence set out in the witness statements of Nyree Wright and KW, neither of which set out a date upon which each attempt to join took place, actually occurred on the 19th during the period when the panel was in private session. The Appellant admitted this in submissions. There is nothing in the assertions made by the Appellant that he was denied access to the public parts of the hearing on any day of the 12 days. The evidence does not prove that in my judgment.

83. The panel considered that series of decisions and breaches committed by the Appellant were serious, occurred over several months, amounted to misconduct and that his fitness to practise was impaired. Despite my decision in relation to charge 2a above I do not consider that the finding of impairment was in anyway inappropriate.

84. In relation to sanction, whilst the Appellant invited the Court to change the sanction to a suspension order, I consider that the panel considered all of the appropriate factors, including the Appellant's previous good character and came to a wholly justifiable decision on the evidence before them and before me. This Appellant was involved in an activity that was inherently risky. He did so in breach of the French legal requirements that he registered with the French regulatory authorities

for midwives. He did so intentionally knowing that he was uninsured and uninsurable. He did so under an unclear contract which was contradictory as to what would happen if the pregnancy went well beyond 40 weeks or the due date was wrong. He then left a vulnerable woman without midwifery support when she was probably long past her due date. He left potentially dangerous medicine in her fridge and he washed his hands of her. This Appellant truly was a black-market midwife operating outside the law on his own poorly drafted terms.

85. As to the Appellant's insight document provided to the appeal court but not the panel, it speaks for itself. It is set out above. It does not help his case at all.

The Appeal

86. Having set out the evidence I should now turn to the Appellant's grounds of appeal against the FTPP's decisions. There are 9 grounds. These are set out below in full:

> "**Grounds for Appeal**
> ● the verdict was wrong and unreasonable. (It couldn't be supported by the evidence) and
> ● the NMC panel made an error of law;.
> ● there was a miscarriage of justice on any grounds (there was misdirection etc including perjury by the prosecution case manager and case presenter)
> ● There was a failure by the panel to test and weigh the 'evidence'
> ○ There were no questions put by the panel to the parties or the witnesses
> ○ There was no cross-examination possible by the Defence
> ○ There was no panel hearing that could be accessed by the Defendant (it was held in secret/private after prior ex-parte hearings)
> ○ .The Defence bundle and witness statements were not considered
> ○ The Defence professional character support statements were not considered
> ● There was cross-contamination of another case by the same NMC case managers/presenters (dropped for lack of evidence although was continued for two years stating serious concerns justified strike off and suspension during the investigation)
> ● Illogical (process and decision)
> ● Discrimination
> ○ (disabilities, - Dyslexia et al,
> ○ Whistleblowing, previous legal actions v NMC etc)
> ● Failing to safeguard vulnerable persons including the registrant
> ● Breach of Human Rights (UNCHR Articles, 3,6,8 14)
> 17 May 2022"

Assessment of the Appellant's presentation

87. I did not see the Appellant give evidence. I did hear submissions from the Appellant for more than one day. The Appellant gave no address to the Court and refused to

inform the Court if he was actually in England between 31st March 2022 and 20th April 2022. The Appellant has not given either the NMC or the Court his address. He says he is of no fixed abode. I did not find that assertion convincing. He refused to provide the NMC with a telephone number yet turned up at court with a mobile phone. He failed to provide his own evidence in the form of a witness statement to the FTPP. He refused to provide a signed witness statement for the appeal until halfway through the first day and then only offered to provide one when prevented from giving unsworn evidence via his submissions.

88. When making his submissions the Appellant tended to make grandiose statements without being able to substantiate them in the documentary or witness evidence. He relied on self-drafted multiple quasi-legal documents which he sent to the NMC at many stages of the disciplinary process, all of which were unhelpful and disruptive and none of which actually engaged with the substance of the charges he faced.

89. When running the appeal the Appellant sought to introduce a wide range of irrelevant documents setting out his multiple legal cases and complaints against various government organisations and regulators seeking to turn the appeal into a cause celebre for independent midwives against regulators generally, instead of focussing on the facts of the serious charges made against him. I make no comment on the broader issues which he has raised.

90. When dealing with the key charges of practising as a midwife without registration and without insurance the Appellant shrugged off his responsibilities as if they were nothing more than chewing gum on his shoe. He downplayed the risks to the mother and the child of childbirth under his ill-written contract in a very troubling way which led me to consider that he is a potential danger to vulnerable women.

91. So, in my judgment, where the Appellant's evidence (unsworn and untested by cross examination as it was) conflicted with evidence from the complainant or Emma Twine, the expert, I generally preferred the evidence of those witnesses over his written assertions and have no reason to consider the FTPP who came to the same conclusion were wrong to do so.

92. **Ground 1: The verdict was wrong and unreasonable. (It couldn't be supported by the evidence).** I have overturned one finding in relation to charge 2a because it was not supported by the evidence put before the panel for the reasons set out in the chronology above. The evidence in relation to it from the complainant (M) was contradictory. Save for that one charge, for the reasons set out above, in my judgment the findings of the panel are unimpeachable and were firmly grounded in the evidence which they heard.

93. **Ground 2: the NMC panel made an error of law**. I have set out above the law relating to the procedure and the evidence before the panel. In my judgement the panel procedure was carried out correctly and the panel made no error of law. Indeed, the Appellant was unable to identify any error of law save as to the assertion that he made that the panel was not empowered to hear hearsay evidence. That submission was wrong in law, the FTPP is empowered by the rules to accept hearsay evidence. The decision on proceeding in the Appellant's absence was made weighing up the relevant factors and was correct in my judgment. The efforts to afford the Appellant the right to defend himself and to call evidence were substantial and enduring but he rebuffed them all. I dismiss this ground of appeal.

94. **Ground 3: there was a miscarriage of justice on any grounds (there was misdirection etc including perjury by the prosecution case manager and case presenter)**. I reject the assertion that the NMC case manager or case presenter behaved in any fashion which was either inappropriate or unprofessional. I consider that the NMC staff's calmness and fairness when dealing with the Appellant's obstructive and disruptive behaviour was exemplary. It is never easy for employed staff to deal with a professional member who asserts dishonesty, perjury, unprofessionalism and unhelpfulness when that member himself, by any objective standards, is being rude and bullying and copying all of the correspondence to the chief executive officer. I dismiss this ground of appeal as baseless.

95. **Ground 4: There was a failure by the panel to test and weigh the 'evidence'.** I dismiss this ground because it is clear from the transcript and the panel's decision that the panel rejected one of the charges (2b) and carefully tested the foundation of the evidence provided by the witnesses called by the NMC on all the other charges (save for 2a). In so far as the panel erred in relation to charge 2a this ground of appeal has succeeded.

96. **Ground 4.1: There were no questions put by the panel to the parties or the witnesses.** I dismiss the first part of this ground of appeal because it is clear from the transcript that the panel asked the questions they needed to ask of the NMC. I dismiss the second part of this ground of appeal because questions were asked by the panel, for instance of the complainant, and are set out clearly in the transcript starting at page 820 of the second bundle for six and a half pages.

97. **Ground 4.2: There was no cross-examination possible by the Defence.** I dismiss this ground of appeal because the reason why there was no cross examination of the NMC witnesses is that the Appellant chose not to engage with the regulator in the preparation for the final hearing and chose not to attend the final hearing until after the panel had made its findings of fact and its decisions on fitness to practise and impairment. On the Appellant's own evidence he attempted to join the online hearing on the 15th April (but not by phone) and then on the 19th of April 2022 only when it was in private session. I reject any finding that the Appellant did in

fact attempt properly to join the online hearing on 15th April. That was Good Friday and the panel were not sitting. He failed to evidence that with any signed witness statement in any event.

98. **Ground 4.3: There was no panel hearing that could be accessed by the Defendant (it was held in secret/private after prior ex-parte hearings).** During his submissions the Appellant accepted that he made no effort to join the final hearing from the 1st of April to the 15th of April 2022. His evidence and that of his witnesses was that they tried to join on the 19th of April 2022 at a time when I have found as a fact that the panel had gone into private session to read the documents which the Appellant had sent to the panel over the Easter weekend before that Tuesday. He was contacted and given the time when the panel would resume in public and he never tried to reconnect thereafter. Instead, he sent in long documents including threats to appeal and further criticisms of the process. I dismiss this ground of appeal because it was founded on untruths.

99. **Ground 4.4: The Defence bundle and witness statements were not considered.** I dismiss this ground of appeal because the Appellant, in my judgment, intentionally refused to take part in the process of preparing for and attending the final hearing. He breached the duty of cooperation set out in Rule 23 of the Code setting out the professional standards of practise and behaviour for nurses and midwives to which he had signed up as a member. He failed to fill in the case management form which I find he was sent in August of 2021. He failed to attend the pre-hearing case conference at which he and the case lawyer would have discussed the evidence for the final hearing. He failed to provide a witness list. He failed to provide any witness statements on which he intended to rely. He failed to provide a bundle for the final hearing. He failed to provide his own witness statement. Instead, he engaged in a disruptive and intentionally destructive course of conduct specifically aimed at making the regulator's task more difficult and at undermining and insulting the regulator's staff.

100. **Ground 4.5: The Defence professional character support statements were not considered.** I dismiss this ground of appeal because the Appellant failed to put before the panel his list of witnesses or his witness statements until the 19th of April 2022. Then, when he did, they were considered. I find as a fact that the panel considered all of the evidence that the Appellant put before them at the last minute on the 19th of April 2022.

101. **Ground 5: There was cross-contamination of another case by the same NMC case managers/presenters (dropped for lack of evidence although was continued for two years stating serious concerns justified strike off and suspension during the investigation).** The Appellant put some evidence before the appeal court about a separate set of disciplinary proceedings which were conducted against him arising from his time at Frimley Park Hospital and which

were eventually terminated by the NMC. I did not have adequate or full documentation in relation to those proceedings nor did I need it. It was irrelevant. However, there was no evidence that those proceedings had any relevance to the case before me or to the decisions made by the case manager or the FTPP members. The panel members are named above. They were independent and, on the evidence before me, no evidence in relation to the other professional conduct allegations was put before them. Nor do I consider that the case manager dealing with this professional conduct case was or is in anyway open to criticism. I dismiss this ground on the basis that it is without foundation in fact.

102. **Ground 6: Illogical (process and decision).** I dismiss this ground of appeal on the basis that it was not made out either on the documentation provided or on the basis of the Appellant's submissions. Both the process before the panel and the decisions made by the panel were in my judgment logical and lawful.

Ground 7: Discrimination:

103. **Ground 7.1: disabilities, - Dyslexia et al**. I dismiss this ground for the following reasons. There was no medical evidence that the Appellant has been diagnosed with dyslexia. The Appellant has not only qualified as a registered general nurse and midwife but also has a masters in law and mediation. It is apparent from the huge amounts of litigation in which the Appellant is involved and from the quasi-legal documents he has drafted and from the written submissions he has filed in this case that the Appellant is perfectly capable of expressing himself in writing. In addition, it was clear to me from the two day appeal hearing that the Appellant is perfectly capable of expressing himself orally too. Furthermore, the demands made by the Appellant just before the final hearing for the NMC to provide him with Wi-Fi and a laptop were in my judgment wholly unfair. The Appellant had refused to provide the NMC with an address or even a country in which he was living. His records showed he lived in New Zealand. He had not corrected that despite having access to his own online account. He refused to provide any address for the NMC. He refused to provide a telephone number. All he would provide was one e-mail address. There was a second e-mail address stored in the online records but the NMC were told by the Appellant not to use it. How the NMC were to judge whether the asserted dyslexia gave rise to a real need for a laptop was not explained by him. How the laptop would be delivered to him was not explained. The Appellant attended at the appeal hearing with a mobile phone and a laptop and used both. No medical evidence was provided in support of any of his other asserted disabilities which would lead this Court to conclude that the Appellant needed to be provided with a laptop by the NMC. In relation to Wi-Fi the request was bizarre. Where was the NMC to provide this Wi-Fi? And in view of the huge Wi-Fi coverage available in most cities I do not understand how the Appellant could have evidenced an inability to access Wi-Fi to be able to attend the final hearing online. Indeed, Wi-Fi is not the only method of attending online hearings. Mobile telephones would permit online connexion through the mobile network. In addition, hard wired

connexion to the Internet is a further route. Finally, the Appellant could have attended the hearing by landline telephone at the number set out in the pre-hearing notices. He chose not to do so.

104. **Ground 7.2: Whistleblowing, previous legal actions v NMC etc.** I dismiss this ground of appeal because no evidence was put before me by the Appellant that he was a whistleblower within the legislation governing whistle blowing. The previous or current legal actions being brought by the Appellant against a wide range of government authorities and statutory authorities was excluded from the appeal because it was irrelevant and none of it was before the FTPP save what the Appellant sent to them just before 19.4.2022.

105. **Ground 8: Failing to safeguard vulnerable persons including the registrant.** I dismiss this ground of appeal firstly on the basis that there was insufficient evidence for a finding that the Appellant was a vulnerable person. Secondly, having seen the Appellant for two days in court representing himself, although he claimed vulnerability including dyslexia, he was able to carry out his submissions with energy and focus by reference to the documents. I have dealt with the lack of evidence in support of any asserted diagnosis above.

106. In a document dated 26.7.2021 on the Court file but not in the bundle the Appellant provided what he considered to be confidential information to the Court about his vulnerabilities. I was not informed whether the (NMC) Respondent was provided with this document. In the body of the document the Appellant suggests that the NMC are aware of it. I have read that and taken it into account. Interestingly that statement has a signature and a date. It is the only one which the Appellant has signed throughout the whole appeal. There is provision in the CPR in Rule 1A for adjustments to be made to assist vulnerable parties but no such application was made.

107. **Ground 9: Breach of Human Rights (UNCHR Articles, 3, 6, 8 14) (sic).** It was not made clear in submissions what this ground related to. It may have related to the Universal Declaration of Human Rights, or it may have related to the European Convention on Human Rights. If it was the former I dismiss it. If it was the European Convention then I dismiss this ground on the bases set out below. Article 3 is a prohibition on torture which has no relevance two this regulatory appeal. As for Article 6, the right to a fair trial, I consider that the Appellant was given repeated and wholly appropriate information, procedural fairness, the opportunity to defend himself and to test the evidence called by the regulator and to call evidence in his defence. However, he chose to deprive himself of the opportunity to defend himself. As for Article 8 of the European Convention, the right to respect for private and family life, I do not consider that the right is relevant to the final decisions. I have already set out above that in my judgment the decisions were lawful and properly made. In relation to the interim suspension order, whilst I have not seen

the documentation leading to the order or the orders I was informed that the Appellant appealed the interim suspension order and that the appeal was unsuccessful save as to a shortening of the length of the suspension. The suspension was in effect up until 29 April 2021 and then and interim conditions of practice order was imposed until the Appellant was struck off the register. I do not consider that this ground of appeal is made out. This was a longstanding statutory regulatory disciplinary process. As for article 14 of the European Convention, which is a prohibition on discrimination, I have dealt with the Appellant's assertions of discrimination above and dismiss this ground of appeal on that asserted basis because there is no sufficient evidence to support it.

Conclusions

108. In this appeal, before the hearing, there appeared to be no issue about two of the breaches found by the FTPP against the Appellant: his lack of registration in France and his lack of insurance. At the appeal he sought to argue that insurance was not necessary for his work in France in the summer of 2019 and that there was, to use his words, "minimal risk" to the mother and the baby. In the light of the judgment of Lang J in *R (Beety)* and the history of independent midwives' insurance I find the Appellant's above assertion to be improper and unprofessional. In my judgment the Appellant was working on the black-market in France as an unlicensed, uninsured midwife, under his own poorly drafted contradictory and unclear contractual terms, creating an obvious risk to women in a vulnerable position.

109. In my judgment the findings in relation to all of the charges found proven by the FTPP were sound and correct save for charge 2a which I overturn and for which I substitute a finding of "not proven". In relation to the finding of impairment of fitness to practice through misconduct, the panel's reasoning was unimpeachable and justified by the evidence. In relation to the panel's decision on continuing the hearing in the Appellant's absence, the correct law was taken into account and the correct principles were applied. This Appellant had been and continued to be obstructive and disruptive to the whole process and then deprived himself of the ability to test the NMC's live and documentary evidence against him and called none of his own, not even himself. In relation to the decision to admit hearsay evidence from Miss Corcoran the panel correctly considered the Rules and the case law and reached a wholly justifiable case management decision in my judgment.

110. The sanction of erasure from the register was appropriate and inevitable in my judgment, in particular because the Appellant's uninsured, unregistered, black-market midwifery, carried out under a poorly drafted contract was a danger to M and her overdue child. Fortunately, no personal injury was suffered because M paid for a private scan and the birth was then induced at a French hospital.

111. For the reasons set out above I overturn the finding that charge 2a was proven, save as to that, the appeal shall be dismissed on all grounds.

112. I invite the Respondent to draw up the order. The Appellant shall pay the Respondent's costs on the standard basis to be assessed if not agreed unless I am persuaded otherwise by submissions. If the parties can agree an order for costs, so much the better. If not, there will be a short consequentials hearing before me which will be arranged in the next 14 days.

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