OUTER HOUSE, COURT OF SESSION

[2021] CSOH 85

P427/20

OPINION OF LORD HARROWER

In the petition of

AB

Petitioner

For judicial review of a decision of the General Medical Council

Petitioner: J Scott QC, D Anderson; Drummond Miller LLP
Respondents: Dean of Faculty; Anderson Strathern LLP

18 August 2021

Introduction

[1] The petitioner's daughter, X, was born in January 2016 and has had a complex medical history. From the age of 3 months, her symptoms included abnormal movements, vomiting, retching and low blood sugars. She was treated from time to time at a specialist children's hospital ("the Hospital"), and prescribed various medications, including anti-convulsants. X developed other problems, not being able to eat by mouth and keep food down, and had a feeding tube (a percutaneous endoscopic gastronomy tube or "PEG tube") inserted in her intestine.

[2] On 2 February 2018, aged 2, X was readmitted to the Hospital, acutely unwell with severe dehydration, vomiting, diarrhoea and high blood sodium levels. Members of the medical team suspected that X's illness might have been "induced", possibly by

administering an osmotically active substance through her PEG tube. On 5 February their concerns were raised with Dr C, the consultant paediatrician at the Hospital with responsibility for child protection. Over the next few weeks, X was kept in the Hospital. Unsupervised access from her mother was stopped. Her medications were stopped. X recovered. Her PEG tube was removed and the stoma where the tube entered the stomach closed off with a removable "button". On 26 March 2018, Dr C co-authored a report which concluded that X's presentation was consistent with "fabricated or induced illness". That report led to the local authority initiating a child protection investigation, as a result of which X was taken into care, though she was eventually allowed to stay with her father. X's parents maintained her illnesses were a side effect of unnecessary medication.

[3] In due course, independent expert reports were obtained, which cast doubt on Dr C's conclusions. The safeguarding proceedings were dropped, and X was reunited with her whole family. In a wide-ranging document running to some 97 pages, the petitioner complained to the respondent, the General Medical Council, regarding Dr C's fitness to practise. The respondent opened an investigation and obtained its own independent expert report, following which it decided to take no further action against Dr C's registration. This case is about whether the respondent's decision disclosed a judicially reviewable error of law. It is not about the merits of the petitioner's original complaint.

The respondent's complaints procedure

[4] The procedure for resolving complaints that a registered practitioner's fitness to practise has been impaired is governed by the Medical Act 1983 and the General Medical Council Fitness to Practise Rules Order of Council 2004. So far as relevant to this petition,

fitness to practise may be impaired by reason of "misconduct" or "deficient professional performance".

[5] The registrar has an initial filtering role, and may conclude a case himself on a number of limited grounds, for example, that it is vexatious, that it is time-barred, or that it does not raise a question of whether a practitioner's fitness to practise is impaired to a degree warranting action on his registration (i.e. by erasure, suspension or the imposition of conditions on the practitioner's right to practise). The registrar may also refer the allegation directly to a medical practitioners tribunal for a full hearing.

[6] Insofar as not dealt with by the registrar, the allegation is referred to the respondent's case examiners (one medical, one lay) for investigation. The case examiners must decide whether the case should proceed further. If they do, then the matter may be referred to a full hearing. They have other powers, which include giving a warning or inviting the practitioner to agree to comply with undertakings of one sort or another. If the case examiners are unable to agree, the decision will be made by the respondent's investigation committee, which has available to it similar options for disposal.

[7] The registrar, on his own initiative or on the application of the complainer, may review the decision of the case examiners if that decision is materially flawed and a review is necessary for the protection of the public, for the prevention of injustice to the practitioner or otherwise necessary in the public interest.

The case examiners' role

[8] There was broad agreement between parties that, for the purposes of this case, the role of the case examiners, when considering whether or not a complaint should proceed, should be taken to be similar to that of the respondent's former Preliminary Proceedings

Committee acting under its previous rules, as described by Mr Justice Lightman in *R* v *General Medical Council, ex parte Toth* 2000 1 WLR 2209, at 2219H to 2220E (the opinion in *ex parte Toth*, formed the basis of an aide-mémoire drawn up for the use of the Preliminary Proceedings Committee, and which has since been approved by Burton, J in *Woods* v *General Medical Council* [2002] EWHC 1484 (Admin)).

[9] The central feature of the respondent's complaints process is the investigation of allegations by a medical practitioners tribunal before whom alone there is full disclosure of documents and evidence and a form of hearing where the complainant and public can see the proper examination of the merits of a complaint. The case examiners have a limited, filtering, role. They may examine whether the complaint has any real prospect of being established, and in so doing may themselves conduct an investigation into its prospects. They may then refuse to refer the allegation on for a full hearing if satisfied that it has no real prospect of being established, but they must do so with the utmost caution (or, at least, with caution: *R* v *General Medical Council, ex parte Richards* [2001] Lloyd's Rep Med 47, *per* Sullivan J, at paragraph 58), bearing in mind that, whilst the practitioner is afforded access to the complaint and able to respond to it, the complainant has no right of access, or to make an informed reply, to that response.

[10] There may be circumstances which entitle the case examiners to hold that the complaint should not proceed for other reasons, but the case examiners must bear in mind their limited (filtering) role and must balance regard for the interests of the practitioner against the interests of the complainant and the public that complaints are fully and properly investigated and that there is no cover-up. Any doubt should be resolved in favour of the investigation proceeding. The case examiners should be particularly slow to

halt a complaint against a practitioner who continues to practise, bearing in mind that the paramount consideration is the protection of the public.

Grounds of review

[11] In this case, the petitioner seeks reduction of the decision of the respondent's assistant registrar (exercising the functions of the registrar, in terms of section 16 of the Medical Act 1983), communicated to the petitioner by letter dated 1 April 2020, declining to review the decision by the respondent's case examiners, communicated to the petitioner by letter dated 26 February 2020, closing the case against Dr C with no action. He does so on the following grounds.

[12] Firstly, in the particular circumstances of this case, it is said that X's illness must have been a result either of her mother's actions, on the one hand, or of unnecessary medication prescribed by Dr C's colleagues at the Hospital, on the other. Any report blaming the petitioner's wife for making X ill, necessarily exonerated Dr C's colleagues (petition, statement 25). Dr C therefore had a conflict of interest such that she should have excluded herself from writing an expert report for child protection purposes (petition, statements 29 and 30). Her failure to do so amounted to misconduct or deficient professional performance. The respondent is said to have failed to take this allegation into account (petition, statement 6 and statement 28).

[13] Secondly, it is alleged that Dr C failed to obtain the informed consent of the petitioner and his wife, as X's legal representatives in terms of the Children (Scotland) Act 1995, to various procedures and treatment while X was an inpatient at the Hospital between 2 February 2018 and 28 March 2018. In concluding that X's parents, by bringing X

to the Hospital on 2 February 2018 for medical management, sufficiently consented to her ongoing treatment, the respondent is said to have erred in law (petition, statement 31).

The case examiners' decision

[14] The case examiners noted the test to be applied was one of "whether there is a realistic prospect of establishing that [the] doctor's fitness to practise is currently impaired to a degree justifying action on her registration". They noted that the test had two parts. The first was whether the allegations, if proven, were serious enough to warrant action on the doctor's registration. The second was whether the allegations were capable of proof to the required standard, namely, that it was more likely than not that the alleged events occurred.

[15] In making their decision, the case examiners were to have regard to the respondent's objectives. These were to protect, promote and maintain the health and safety of the public; to promote and maintain public confidence in the profession; and to promote and maintain proper standards and conduct for members of the profession.

[16] The case examiners then noted relevant paragraphs from the respondent's own guidance *Good Medical Practice* and *Protecting Children and Young People*. That guidance included the need to be honest and trustworthy when writing reports, and to make sure they are not false or misleading. It also included the need to be satisfied that the doctor had consent before carrying out any examination or investigation, or providing treatment.

[17] So far as the first part of the test was concerned, the case examiners were satisfied that the allegations contained in the complaint were sufficiently serious to warrant action on Dr C's registration. As for the second part, the case examiners had regard to the advice of the independent expert instructed by the registrar. They noted certain aspects of the

independent expert's advice, which, so far as relevant to those aspects of the complaint that are the subject of the present petition, were as follows:

- "that Dr [C]'s role was the named safeguarding health professional. In this capacity her responsibilities were to oversee the management of Patient [X]'s care, liaising with social services, the police and any other agency to protect the child's best interests. She also made appropriate referrals to other clinicians, for example, she referred Patient [X] to the plastic surgery team for a lump over her right orbit

- that the day to day management of Patient [X] was the responsibility of the medical and nursing staff who attended to Patient [X] and who saw her on daily ward rounds

- various points from the FII (A Practical Guide) Practice Points to support Dr [C]'s actions. This included that the guide:

    - recommended that there should not be any need to confirm the diagnosis before referring to children's social care as delay may be detrimental to the child

    - stated, '[a]t this stage concerns about FII cannot be discussed with the family as the child may be put at risk.'

- that the decision to make a child protection order was made at a multiagency discussion on 26 March 2018, about Patient [X]'s welfare. Although consultations were made with other team members and social services, neither parent consented to a voluntary arrangement for Patient [X] to be placed in foster care. It was therefore decided that a child protection order would be applied for in the best interests of the child

- that once a decision was made for the Scottish Sherriff's [sic] Office to determine what was in the best interests of Patient [X], it was not within Dr [C]'s gift to determine the outcome

- Dr [C] had consented to an independent review of the clinical aspects of the case."

[18] The case examiners then summarised the experts conclusions, which, again, so far as relevant to the subject matter of the present petition, were as follows:

"The safeguarding referral
[…]

- Dr [C] had made an appropriate safeguarding referral which was aligned with the FII guidelines issued by the RCPCH

- in writing her report, Dr [C] adequately considered Patient [X]'s previous medical history noting that she had included a full chronology on the care of Patient [X] in her report to the Children's Reporter for Scotland
[…]
- in keeping with FII guidelines, Dr [C] considered the wider differential diagnosis in place of FII and detailed these in her report

- there was no significant delay in providing a comprehensive medical report for social services. He noted that it takes time for medical records and GP records to arrive and be collated and that Patient [X]'s period of observation in hospital allowed the medical team to document any abnormalities in carer-child interaction and to obtain a full picture of the child and family

- he did not see any evidence of bias in Dr [C]'s report. He stated that the report was 'comprehensive and balanced' and 'carefully considers other possibilities in place of FII to explain Patient [X]'s symptoms.'

Consent

The expert said that the consent for Patient [X]'s care was implied consent. He explained, '[t]he fact that Patient [X] was an inpatient in [the Hospital] and had been brought there by her parent(s) on 02.02.18 for medical management was sufficient consent for her ongoing treatment.'

The expert also noted that during a telephone consultation with [the petitioner] on 21 February 2018, Dr [C] explained that her role was as a child protection consultant and she worked between her paediatric colleagues, social services and the police to relay concerns. She also explained that she was the health contact for colleagues […] (where the family resided). The expert recognised that although [the petitioner] was not satisfied with the responses given by Dr [C], he did not state at any point that he did not consent to the ongoing treatment and care and multiagency strategy meetings planned for Patient X.

Answering basic medical questions

The expert noted that the majority of basic questions were addressed by the doctors who performed daily rounds. In her capacity as safeguarding lead, Dr [C] kept Patient [X]'s parents informed in relation to relevant matters related to safeguarding and welfare issues. This included at a discharge planning meeting on 26 March 2018 when Dr [C] (and others present) gave both parents … the opportunity to ask questions about 'Patient [X]'s medical care received to date and her welfare in respect of safeguarding issues.'"

[19] The case examiners further noted that the expert had not identified any aspects of Dr C's care "that fell below, or seriously below" the standard of the reasonably competent consultant paediatrician and lead consultant paediatrician for child protection. They also noted that the expert had confirmed that Dr C had followed the guidance issued by the Royal College of Paediatrics and Child Health in *Fabricated or Induced Illness by Carers (FII): A Practical Guide for Paediatricians* ("the RCPCH guidance") and that she had made the appropriate referrals to police and social services. The case examiners accepted the expert's advice and concluded that there was no realistic prospect of establishing that Dr C's fitness to practise was impaired, and that it would not be appropriate or proportionate to issue a warning.

[20] By letter dated 1 April 2020, the respondent wrote to the petitioner, enclosing the assistant registrar's decision, concluding that there were no grounds on which to review the case examiners' decision. It was not materially flawed, and the petitioner had presented no new information which might have led to a different decision.

Argument for the petitioner

[21] Adopting her Note of Argument at the substantive hearing, senior counsel for the petitioner submitted that "misconduct" had no "absolute meaning" and it was impossible in changing circumstances and new eventualities to prescribe a complete catalogue of the forms of professional misconduct which may lead to disciplinary action (*Roylance* v *General Medical Council (No 2)* [2000] 1 AC 311 *per* Lord Clyde at pp 330 and 331; and *Nandi* v *General Medical Council* [2004] EWHC 2317 (Admin) *per* Collins J, at paragraph 31). Members of the medical practitioners tribunal were well placed in the light of their own experience, whether lay or professional, to decide where the line should be drawn in the circumstances of

particular cases, and their skill and knowledge required to be respected. Misconduct involved some act or omission which fell short of what would be proper in the circumstances.

[22] Two particular features of the circumstances in which Dr C came to write her report, and which the respondent failed to take into account, gave rise to a conflict of interest.

[23] The first was that Dr C's report set in motion a chain of legal consequences. The social work authorities were "duty bound" to seek a child protection order. The application would be *ex parte*, and the sheriff would have "little choice" but to grant it. Once the child protection order was made, the reporter to the children's hearing would be "bound" to arrange a hearing, at which a parent would "not be in a position" to challenge the need for the order. Given the terms of the report, it would "inevitably result" in a decision to refer the matter to the children's hearing. The report thus had the "inevitable" consequence that X would be removed from her family "unless and until [Dr C] was shown to be wrong".

[24] In this connection, the petition relied on the contention that Dr C, when providing her report, was acting as an expert, and, as an expert, was not in a position to give independent and impartial advice (statements 6, 25 and 26 under reference to *Porter* v *Magill* 2002 2 AC 357, and *Kennedy* v *Cordia (Services) LLP* 2016 SC (UKSC) 59). As developed in the Note of Argument, the argument was that Dr C's report set out an "expert opinion" which was "designed to be used, and actually used" for the purpose of securing a child protection order, and then forming the basis for the drafting of grounds of referral.

[25] The second feature was that Dr C was confronted with a "stark choice" between accepting, on the one hand, that her colleagues at the Hospital had misdiagnosed X's earlier condition resulting in damage from the side effects of anti-convulsant medication and the

insertion of a PEG tube, and, on the other, that X was the victim of fabricated or induced illness ("FII").

[26] The combination of these two features in the circumstances of X's case meant that Dr C "owed a duty" to X and her parents to seek specialist, independent advice before providing her 26 March 2018 report. There was ample time between X's admission on 2 February 2018 and the provision by Dr C of her report to obtain that advice.

[27] When considering the relevant guidance, it was insufficient to have regard only to the terms in which that guidance was expressed; one had to have regard to its "spirit" (under reference to *Edward Wong Ltd* v *Johnson, Stokes & Master* [1984] AC 296). But the duty contended for - to seek specialist, independent advice - was in any event consistent with the respondent's guidance in *Good Medical Practice.* Reference was made to the need promptly to provide suitable advice or investigations where necessary (paragraph 15b); to consult with colleagues where appropriate (paragraph 16d); to consider the needs and welfare of any child patient (paragraph 27); to make good use of the resources available (paragraph 18); to make sure that the practitioner's conduct justified the patient's trust in her and the public's trust in the profession (paragraph 65); to be honest and trustworthy when writing reports or giving evidence, to make sure that any reports or evidence were not false or misleading, and to take reasonable steps to check that the information given was correct (paragraphs 71 and 72); and when faced with a conflict of interest specifically in financial dealings, to be open about the conflict, declaring one's interest formally, and to be prepared to exclude oneself from decision making (paragraph 79).

[28] The duty to seek specialist, independent advice was also said to be consistent with the RCPCH guidance. Reference was made to FII being rare (paragraph 3.3); to the need to distinguish between the anxious carer responding in a reasonable way to a sick child, and

the rare case of the carer whose behaviour risks causing harm by confusing and possibly fabricating the presentation (paragraph 5.1); to the need for an apology for any distress caused, where additional information emerges indicating a previously unrecognised genuine illness, and to the need for an assurance that the child will not be subject to a child protection plan (paragraph 5.54); to the fact that there will be situations where urgent referral to children's social care is required (paragraph 6.1); to the inappropriateness of delaying referral to children's social care pending confirmation of FII (paragraph 6.4); to the range of matters that should be considered in any strategy discussion regarding possible FII, including any outstanding investigations, further information gathering, and opinions that would be helpful or necessary (including specialist child protection opinion or to address a specific clinical issue) (paragraph 6.9); and in the context of disclosure of the possibility of FII to the carer, to the range of matters that may be included in that discussion, such as, the reasons why the identification of FII seemed likely, any other possible causes for the child's signs and symptoms, and any further investigations and their likely impact on the decision regarding FII (paragraph 7.3).

[29] Senior counsel further submitted that the case examiners had applied the wrong test to the question of whether or not consent had been obtained. The respondent's guidance in *Good Medical Practice* required the practitioner to be satisfied that she had consent or other valid authority before carrying out any examination or investigation or providing treatment (paragraph 17). The notion that consent to ongoing treatment was "implied" by the fact that X had been brought to the Hospital for medical management, and not subsequently withdrawn, was "outdated" (petition, statement 31) and inconsistent with both the Supreme Court's decision in *Montgomery* v *Lanarkshire Health Board* 2015 SC (UKSC) 63, and the respondent's guidance.

Argument for the respondent

[30] On behalf of the respondent, the Dean of Faculty argued that it was misconceived to regard Dr C as acting as an expert when writing her report. Rather, she was simply acting in her role as the clinician responsible for the well-being of X whilst in the Hospital. Senior counsel for the petitioner had not suggested that Dr C's concerns were anything other than genuine. Those concerns were that X had suffered FII at the hands of a parent. In the circumstances, she was professionally obliged to act upon those concerns.

[31] The petitioner's suggestion that a clinician in such a situation would find herself in a position of conflict, because blaming the parent in some way exculpated the clinical team, was unfounded. If it were correct, a clinician involved in the care of a child, who had concerns about possible harm from a parent, could never act upon those concerns by writing a report for child protection purposes, or even by reporting the matter to the police. The position advanced by the petitioner was unworkable and dangerous.

[32] In any event, in writing a report for child protection purposes, such as that provided by Dr C, the clinician was not acting as an "expert", in the sense discussed in *Kennedy* v *Cordia (Services) LLP* 2016 S.C. (UKSC) 59. An expert witness in the course of litigation was there to testify, in an independent and impartial manner, on matters relating to his particular expertise. It is that expertise that qualified the expert, unlike other witnesses, to give opinion evidence. A clinician making a reference in the circumstances presently under consideration, was not offering evidence at all, let alone opinion evidence. She was merely bringing to the attention of the proper authority concerns which had arisen in the course of caring for a child. In any event, it was commonplace for an employee of a defender, if sufficiently qualified, to give opinion evidence. Being an employee goes to weight, not

admissibility: *R (Factortame Limited)* v *Secretary of State for Transport, Local Government and the Regions (No. 8)* [2003] QB 381; *Field* v *Leeds City Council* (2000) 32 HLR 618.

[33] The Dean of Faculty drew support from the RCPCH guidance which stated at paragraph 5.28, "if at all possible, the case should continue to be managed by the same medical team in the same setting throughout its duration. A change of medical team at any stage can cause delays in the identification of FII thereby increasing the risk of further harm to the child". And, at 6.1, it stated:

> "there will be situations when an urgent referral to children's social care is required… If a paediatrician is concerned about the immediate safety of the child then a referral must be made, particularly in the case of suspected non-accidental poisoning and suffocation".

[34] In addition, the Dean of Faculty referred to the respondent's guidance, *Protecting Children and Young People*, which required all doctors to act on any concerns they had about the safety or welfare of a child, and stated that, where the interests and wishes of parents put the child's safety at risk, they must put the interests of the child first. "Taking action will be justified", the guidance said, "even if it turns out that the child … is not at risk of, or suffering, abuse or neglect, as long as the concerns are honestly held and reasonable, and the doctor takes action through appropriate channels". Doctors were required to tell an appropriate agency, such as the local authority children's services, or the police, promptly if they are concerned that a child is at risk of or is suffering from abuse. They were told that they do not need to be certain that the child is at risk:

> "If a child … is at risk of, or is suffering, abuse or neglect, the possible consequences of not sharing relevant information will, in the overwhelming majority of cases, outweigh any harm that sharing your concerns with an appropriate agency might cause" (paragraph 32).

[35] On the issue of consent, the Dean of Faculty argued that, by taking X into the Hospital as a result of ill health, the parents provided the Hospital and its staff with the necessary consent to treat X. The case of *Montgomery* did not suggest that, in such circumstances, a hospital (and all of its staff) should be paralysed, unable to act in any way unless and until parental consent had been given for each and every step in the treatment and investigation of a patient. *Montgomery* was distinguished as being a case about the test for medical negligence in a situation where a patient sustained injury in the course of a procedure to which she consented but in respect of which there were alternatives that she was not told about. It was not a case about proper professional conduct in the course of clinical practice. In the absence of identification of injury to X arising from treatment or procedure to which an alternative should have been given, *Montgomery* was simply of no relevance. The case examiners had made no error of law in their decision. Alternatively, they had not been shown to have acted unreasonably in deciding that the complaint should not proceed further.

Decision

[36] I have decided that the petition should be dismissed, for the following reasons.

Conflict of interest

[37] The first ground of review is that the case examiners "failed to consider" the petitioner's allegation that Dr C had a conflict of interest when submitting her 26 March 2018 report. The starting point for considering any such argument must be the case examiners' reasons for their decision. Interestingly, the phrase "conflict of interest" does not figure in the case examiners' reasons, including those parts of the independent expert's advice noted

by them. However it does not follow that either the case examiners or the independent expert failed to have regard to this aspect of the petitioner's complaint. The case examiners noted that the expert was asked to comment on whether Dr C "appropriately made a safeguarding referral". The "appropriateness of the safeguarding referral" is a much more general rubric that is apt to refer not just to Dr C's alleged conflict of interest, but also to the whole congeries of allegations made by the petitioner that focussed on Dr C's role in the referral process. These included repeated allegations of bad faith and of actual bias on the part of Dr C. And although senior counsel made it absolutely clear that these very serious allegations formed no part of the subject matter of the present proceedings, in order properly to understand the case examiners' decision, it is important not to lose sight of the actual complaint that was before them. In particular, while stripping away bad faith and actual bias arguments from the present petition may have brought a welcome clarity to proceedings, it also gave the conflict of interest argument a degree of prominence which it lacked in the original complaint. In my opinion, the reasonable reader would have understood the case examiners to be addressing Dr C's alleged conflict of interest as one issue amongst others relating to the appropriateness of the safeguarding referral.

[38] This interpretation is confirmed by a closer reading of those aspects of the expert report highlighted by the case examiners in a series of bullet points (and reproduced at paragraphs 17 and 18 of this opinion). In the first two bullet points, it was noted that Dr C was not responsible for the "day to day management" of X's care, but rather was "the named safeguarding health professional". As such, her responsibilities were to "oversee the management of X's care", and to "liaise with social services, the police and any other agency to protect the child's best interests". In implement of these responsibilities, she would be obliged to report her concerns regarding X and the possibility of FII to the multi-agency

team and the local authority. The reasonable reader would have understood the case examiners to be confirming that Dr C would be neither barred nor excused from carrying out these responsibilities simply because an alternative explanation for X's illness might be found in the treatment provided by Dr C's colleagues.

[39] In the first bullet point of the conclusions (paragraph 18, above), it was noted that the appropriateness of the safeguarding referral was "aligned with the FII guidelines issued by the RCPCH". (I note in passing that the current RCPCH guidance is *Perplexing Presentations (PP)/Fabricated or Induced Illness (FII) in children*, but this only superseded the 2009 guidance in March 2021, and therefore does not apply to the present case.) Particular reference was made by the case examiners to a recommendation directed at the "initial management" of the case, where the practitioner is told not to wait to confirm the diagnosis before referring to children's social care, "as delay may be detrimental to the child" (p21). This should be read together with the recommendation in the same 2009 guidance, directed at the "further medical management" of the case, and which tells the practitioner to "resist requests for a change of clinical team or hospital as this may place the child at risk of harm" (p28). The case should be managed "by the same medical team in the same setting throughout its duration" (paragraph 5.28), as a change of medical team at any stage "can cause delays in the identification of FII thereby increasing the risk of further harm to the child".

[40] Apparently, it had previously been thought that cases of FII "should be managed by a doctor with specific expertise from *outside the situation in which the identification was made*" (emphasis supplied), but, at least by the time of the 2009 guidance, this was no longer regarded as best practice other than in exceptional cases (paragraph 5.27). The significance of the case examiners' reference to the RCPCH guidance, as the reasonable reader would have understood, is that it highlighted the importance of Dr C retaining control of the case

as the lead child protection consultant, notwithstanding that there may have been allegations made against the medical team.

[41] This is sufficient to deal with the case on record, but at this point it is convenient to note a subtle but significant shift in the petitioner's argument. Whilst the petition is premised on a failure by Dr C to "exclude herself" from the provision of a report for child protection purposes (paragraphs 28, 29 and 30), the argument at the substantive hearing was only that Dr C failed to seek independent, specialist advice before providing her 26 March 2018 report. This is not a mere pleading point, since the more extreme position adopted in the petition, and not advanced at the substantive hearing, was the only version of the argument put forward by the petitioner in his original complaint. In my view, the case examiners can scarcely be criticised for not considering an argument that was never suggested to them.

[42] In any event, this modified version of the argument - that Dr C failed to seek independent, specialist advice – soon runs into new difficulties of its own. Firstly, if the mischief at which it is directed is intended to be a perceived conflict of interest, then it is far from clear that it goes far enough as a response. In other words, if Dr C genuinely had a conflict of interest, why indeed should she not exclude herself from decision-making, or at least declare her interest? Surely, it would not be enough merely to take independent, specialist advice, since she would retain the ultimate decision-making role regarding what to include in her report, including whether to disregard that advice. So, whilst the modified argument may seem more attractive than the extreme position that required Dr C to exclude herself from any involvement in writing a report, it does so at the cost of being inconsistent with the very mischief it is designed to address, namely, the alleged conflict of interest.

[43] Of course, this is not to suggest that there it will never be appropriate to seek independent, specialist advice. Quite the opposite. As is noted in the RCPCH guidance, the assessment of FII is complex, and it may be necessary to involve an appropriate, tertiary specialist, provided overall management of the case remains with the responsible paediatric consultant (paragraph 5.24). However, the appropriateness of that course of action turns on the need for specialist advice at the tertiary level, rather than the referring consultant herself being disabled from carrying out her secondary level role by reason of any conflict of interest.

[44] It may be worth noting in passing that Dr C did in fact seek independent, specialist advice from a consultant nephrologist prior to making her 26 March 2018 report, albeit the advice was given on an informal basis, and on the understanding that Dr C would not rely on it for medico-legal purposes, since the specialist did not have access to the details of X's case or her notes. This raises the further question, if there were to be something in the nature of a duty to seek independent, specialist advice, in the circumstances of this case, of what exactly that duty would look like. Would it be enough to have sought that advice on an informal basis, as Dr C did? Or would it have been necessary to provide full access to the patient's notes and clinical information, and obtain a "formal" report? The RCPCH guidance notes only that tertiary specialists should be "carefully briefed" and "the remit of their involvement … clearly delineated" (paragraph 5.24). The precise contours of the alleged duty to seek independent, specialist advice were not discussed at the substantive hearing, but given the view that I have taken, that the case examiners adequately addressed the allegation of an alleged conflict of interest, it is unnecessary for me to explore the matter further here.

[45] I consider that the Dean of Faculty was well-founded in his criticism of the petitioner's pleaded case that, in writing her report, Dr C was acting as an "expert". However, as already noted, by the time of the substantive hearing, the petitioner's argument was rather that the case examiners erred by "failing to take into account" the "considerable power" of Dr C's report, which "inevitably" set off a whole chain of legal consequences. At least two aspects of the independent expert's report, as noted by the case examiners, were relevant to this part of the discussion. Firstly, the expert noted that the decision to apply for a child protection order was made at a "multiagency discussion", rather than specifically by Dr C. Secondly, once the matter was put into the hands of the court, it was said to be "not within Dr [C]'s gift to determine the outcome". Senior counsel for the petitioner might well disagree with these conclusions; she might say that Dr C's report was of such "power" that it had already determined the outcome, at least until a contrary report had been produced: but it cannot be maintained that the case examiners failed to consider the role of Dr C's report within the context of the regulatory framework of which it formed part.

[46] Senior counsel for the petitioner also maintained that the case examiners failed to consider the peculiar circumstances of this case, namely, the "stark choice" facing Dr C, between, on the one hand, admitting that her colleagues at the Hospital had misdiagnosed X's earlier condition resulting in damage from the side effects of prescribed medication, and, on the other, the conclusion that X was the victim of FII. However, this analysis was not the position put forward by the petitioner in his complaint. He stated, "Two things happened concurrently with [X]'s recovery: [Her mother] was prevented from having unsupervised contact with [X], and the medication prescribed to her by doctors at [the Hospital] was stopped. *One, both, or neither of these factors could have been a cause of the recovery…*" (emphasis supplied). In other words, the either/or position adopted in these judicial review

proceedings formed no part of the petitioner's complaint. Once again, the case examiners can scarcely be criticised for not considering what was not suggested to them.

[47] In any event, the expert did at least acknowledge that, "in keeping with FII guidelines", Dr C had "considered the wider differential diagnosis in place of FII and detailed these in her report". He is here referring to Dr C's later report which had been requested by the Reporter. But even in her 26 March 2018 report, Dr C had considered and provided a detailed account of the petitioner's theory that X's illnesses were attributable to her medications. The case examiners clearly concluded, as the reasonable reader would have understood, that Dr C had been candid about the petitioner's alternative explanation for X's illness. Whether or not that gave rise to a need to instruct an independent expert report would be a matter for the Reporter or the court to consider.

[48] For all these reasons I would reject the petitioner's argument that the case examiners failed to consider that Dr C had a conflict of interest requiring her either to exclude herself from decision-making, or to seek independent, specialist advice before providing her 26 March 2018 report.

Consent

[49] The petitioner's second ground of review is that the case examiners erred in law by applying the wrong test to the question of consent. I agree with the Dean of Faculty that the case of *Montgomery* does not apply to the present case. *Montgomery* clarified the existence of the patient's right to decide whether or not to accept a proposed course of treatment, in circumstances where alternative treatments were reasonably available. Since the right could only be exercised on an informed basis, the patient in such circumstances required to be advised of the risks involved in opting for the particular course of treatment or rejecting it

(*McCulloch* v *Forth Valley Health Board* 2021 SLT 695). Since the petitioner does not aver any alternative course of treatment reasonably available to X, *Montgomery* has no application to the circumstances of the present case.

[50] Nor am I persuaded that the case examiners made any error of law when they concluded that X's parents, by bringing her to the Hospital, had given consent to her ongoing treatment. At the very least there would require to be averments of the specific factual situation in which it might be said that implied consent to ongoing treatment ceased to apply, or was withdrawn. The petition contains no such averments.

[51] There is a suggestion in the petitioner's Note of Argument that the case examiners "failed to consider" an allegation of a failure to provide X's parents with information to enable them to give informed consent to the removal of the feeding tube. This appears to relate to the decision, once feeding via the tube had been stopped, to close off the stoma with a removable "button". In statement 9 of the petition, it is averred that, "Dr C did not inform the petitioner … that she would support foster care for [X] if her 'button' was not removed and the stoma surgically closed". It is unclear to me how precisely this averment is intended to relate to the petitioner's complaint. If I have understood the original complaint correctly, the removable button, precisely because it was removable, was seen by the medical team as presenting a risk that X, if allowed to return home, could be subjected to further induced injury. What the petitioner objected to was not being adequately informed that a permanent surgical closing off of the stoma had been an available treatment option, which might have allowed X to remain with the family rather than being taken into care. If this is a correct understanding of the complaint, I do not consider it is adequately focussed in the petitioner's pleaded case. It is not clearly set out in the petition itself, and insofar as it is set out at all in the Note of Argument, it is said to be an allegation that the case examiners failed

to consider. However, the petitioner's case on the issue of consent is not based on a failure to consider, but on the case examiners having applied the wrong test and erred in law, and I have already rejected that argument.

[52] Even if I were to entertain the argument as a "failure to consider" point, I would have rejected it. At the foot of page 1 of their decision, the case examiners stated, "When Dr [C] said that [X] could go home on 26 March and that there was a plan to remove her feeding tube prior to discharge, Dr [C] allegedly did not provide [X]'s parents with any information to enable them to give informed consent to this procedure". Standing that specific acknowledgment of the alleged failure to obtain informed consent, I cannot accept the argument that the case examiners failed to consider it.

[53] The case examiners accepted that the allegations in the complaint were serious enough to warrant action on Dr C's registration. That was inevitable given the allegations of bad faith and actual bias. It is perhaps an open question whether it remains the case in respect of the more limited allegations that formed the subject matter of the present proceedings; in other words, whether either ground of review, even if it were well founded, was sufficiently serious to warrant action on Dr C's registration. Probably that question would have required to be considered afresh by the case examiners, had I been minded to grant the orders sought, but since I was not addressed on it at the substantive hearing, I would reserve my opinion on the matter.

Disposal

[54] I shall sustain the respondent's first plea in law and dismiss the petition, reserving all question of expenses.

[55] At the substantive hearing, senior counsel for the petitioner moved the court to grant an order to protect X's identity, in terms of section 46(1)(a) and (b) of the Children and Young Persons (Scotland) Act 1937, the court having already made such an order, on an interim basis. While this case was at avizandum, I was advised that the petitioner no longer sought the order craved, since it had come to light that, prior to the interim order being granted, substantial publicity had already been given to X's identity in connection with the matters with which these proceedings are concerned, both nationally and internationally. In light of that information, I recalled the interim order. However, while the reporting restriction itself may no longer have been justified, I also took the view that X's welfare was still a relevant consideration justifying the anonymisation of her identity in this opinion. I have also sought to protect Dr C's identity, and the integrity of the respondent's own complaints procedure, since whatever my decision in these judicial review proceedings, publication would be a matter for the respondent, in accordance with its policy, and indeed section 35B of the Medical Act 1983. I have therefore anonymised, in this opinion, all references to the child, her parents, the registrant and the Hospital.