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DR DAVID SOUTHALL

FTP HEARING (PPC AND PCC RULES 1988)

13 NOVEMBER – 2 DECEMBER 2006

5 NOVEMBER – 7 DECEMBER 2007

COMPLAINANT'S EXHIBIT LIST

Amended Appendices

- C1 - Panel Bundle 1**
- C2 - Panel Bundle 2**
- C3 - Panel Bundle 3**
- C4 - Judgement of His Honour Judge Tonking, dated 10 March 1998
Shropshire County Council and Ms M and Mr M**
- C5 - S/C File Patient A and B**
- C6 - S/C File Patient D**
- C7 - S/C File Patient H**
- C8 - Witness statement of Ms Sarah Ellson dated 15 November 2006**
- C9 - Appendix one documents**
- C10 - Appendix two documents**
- C11 - Drawing by Ms D – corridor/room lay out**
- C12 - Letter from FFW to Huttons Solicitors dated 7 October 1994**
- C13 - Letter from The Gowerton Practice to FFW dated 24 August 2006**
- C14 - Guide on "What is clinical audit?" produced by UBHT Clinical
Audit Central Office**
- C15 - The Victoria Climbié Inquiry – recommendations**
- C16 - Panel Bundle: Clinical Correspondence**
- C17 - Child B – Documents from the faxed clip in the original file**
- C18 - Report from [REDACTED] dated 7 May 1998**

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- C19 - Analysis of record keeping policies and protocols**
- C20 - Mrs A's search for medical records**
- C21 - Mrs D's search for medical records**
- C22 - Mrs H's search for medical records**
- C23 - GMC – Professional Conduct and Discipline: Fitness to Practise
(March 1989)**
- C24 - Complainant's skeletal closing submission**
- C25 - Correspondence regarding undertakings**
- C26 - Attorney General's view**
- C27 - Fitness to Practise History**

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DR DAVID SOUTHALL

FTP HEARING (PPC AND PCC RULES 1988)

13 NOVEMBER – 2 DECEMBER 2006

5 NOVEMBER – 30 NOVEMBER 2007

DEFENCE EXHIBIT LIST

- D1 - [REDACTED]
- D2 - Letter from [REDACTED] dated 1 August 1994
- D3 - [REDACTED] telephone attendance note dated 15 April 1998
- D4 - Letter from [REDACTED] to [REDACTED] dated 24 April 1998
- D5 - Letter from [REDACTED] to [REDACTED] dated 25 September 1987
- D6 - Letter from [REDACTED] to [REDACTED] dated 9 November 2006
- D7 - Letter from [REDACTED] to [REDACTED] dated 4 January 1995
- D8 - Letter from [REDACTED] to [REDACTED] dated 14 July 1994
- D9 - Admissions in relation to Appendix 1
- D10 - 'Galbraith' extract from Archbold – No case to answer
- D11 - Dr Southall Curriculum Vitae
- D12 - Child A – Records
- D13 - Child H – Records
- D14 - Child B – Records
- D15 - Brompton Hospital – Patient Data Sheet/ Medical report prepared by Dr Southall dated 27 June 1991

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- D16 - Child B – Medical record relating to admission on 1 September 1993
- D17 - Page 16 of [REDACTED] dated 24 October 1991
- D18 - [REDACTED]
- D19 - Department of Health guidelines (2002)
- D20 - North Staffordshire: Procedure and guidance for the recording of child protection information where fabricated or induced illness is suspected (2006)
- D21 - [REDACTED] Documents
 - D21a [REDACTED] CV
 - D21b Children's Act 1989 – Section 1
 - D21c Children's Act 1989 – Section 47
 - D21d Referral details – 16/1/98
 - D21e Notes of strategy meeting
 - D21f Contact sheet
 - D21g Contact sheet
 - D21h Handwritten notes written on 27.04.98
 - D21i Handwritten notes - undated
 - D21j Contact sheet – [REDACTED]
 - D21k File note from legal file (dated 06.05.98)
- D22 - Letter from Dr Southall to [REDACTED] dated 23 July 1993
- D23 - Head Note of judgement: [2005] UKHL 23
*D v East Berkshire Community NHS Trust & Others
MAK and another v Dewsbury Healthcare NHS Trust and another
RK and another v Oldham NHS Trust and another*
- D24 - Extract: Transcript from PCC hearing on 5 August 2004
Evidence of Dr Chipping
- D25 - Letter from [REDACTED] dated 6 July 2007
- D26 - Bundle of testimonials

- 1 **Recommendation 56** Directors of social services must ensure that no child known to social services who is an inpatient in a hospital and about whom there are child protection concerns is allowed to be taken home until it has been established by social services that the home environment is safe, the concerns of the medical staff have been fully addressed, and there is a social work plan in place for the ongoing promotion and safeguarding of that child's welfare. (paragraph 6.594)
- 2 **Recommendation 57** Directors of social services must ensure that social work staff are made aware of how to access effectively information concerning vulnerable children which may be held in other countries. (paragraph 6.619)
- 1 **Recommendation 58** Directors of social services must ensure that every child's case file includes, on the inside of the front cover, a properly maintained chronology. (paragraph 6.629)
- 2 **Recommendation 59** Directors of social services must ensure that staff working with vulnerable children and families are provided with up-to-date procedures, protocols and guidance. Such practice guidance must be located in a single-source document. The work should be monitored so as to ensure procedures are followed. (paragraph 8.7)
- 2 **Recommendation 60** Directors of social services must ensure that hospital social workers working with children and families are line managed by the children and families' section of their social services department. (paragraph 8.19)
- 1 **Recommendation 61** Directors of social services must ensure that hospital social workers participate in all hospital meetings concerned with the safeguarding of children. (paragraph 8.27)
- 2 **Recommendation 62** Where hospital-based social work staff come into contact with children from other local authority areas, the directors of social services of their employing authorities must ensure that they work to a single set of guidance agreed by all the authorities concerned. (paragraph 8.53)
- 1 **Recommendation 63** Hospital social workers must always respond promptly to any referral of suspected deliberate harm to a child. They must see and talk to the child, to the child's carer and to those responsible for the care of the child in hospital, while avoiding the risk of appearing to coach the child. (paragraph 8.100)

Healthcare recommendations

- 1 **Recommendation 64** When a child is admitted to hospital and deliberate harm is suspected, the nursing care plan must take full account of this diagnosis. (paragraph 9.35)
- 2 **Recommendation 65** When the deliberate harm of a child is identified as a possibility, the examining doctor should consider whether taking a history directly from the child is in that child's best interests. When that is so, the history should be taken even when the consent of the carer has not been obtained, with the reason for dispensing with consent recorded by the examining doctor. *Working Together* guidance should be amended accordingly. In those cases in which English is not the first language of the child concerned, the use of an interpreter should be considered. (paragraph 9.39)

- 1 **Recommendation 66** When a child has been examined by a doctor, and concerns about deliberate harm have been raised, no subsequent appraisal of these concerns should be considered complete until each of the concerns has been fully addressed, accounted for and documented. (paragraph 9.60)
- 2 **Recommendation 67** When differences of medical opinion occur in relation to the diagnosis of possible deliberate harm to a child, a recorded discussion must take place between the persons holding the different views. When the deliberate harm of a child has been raised as an alternative diagnosis to a purely medical one, the diagnosis of deliberate harm must not be rejected without full discussion and, if necessary, obtaining a further opinion. (paragraph 9.65)
- 1 **Recommendation 68** When concerns about the deliberate harm of a child have been raised, doctors must ensure that comprehensive and contemporaneous notes are made of these concerns. If doctors are unable to make their own notes, they must be clear about what it is they wish to have recorded on their behalf. (paragraphs 9.72 and 10.30)
- 1 **Recommendation 69** When concerns about the deliberate harm of a child have been raised, a record must be kept in the case notes of all discussions about the child, including telephone conversations. When doctors and nurses are working in circumstances in which case notes are not available to them, a record of all discussions must be entered in the case notes at the earliest opportunity so that this becomes part of the child's permanent health record. (paragraph 9.95)
- 2 **Recommendation 70** Hospital trust chief executives must introduce systems to ensure that no child about whom there are child protection concerns is discharged from hospital without the permission of either the consultant in charge of the child's care or of a paediatrician above the grade of senior house officer. Hospital chief executives must introduce systems to monitor compliance with this recommendation. (paragraphs 9.101 and 10.145)
- 2 **Recommendation 71** Hospital trust chief executives must introduce systems to ensure that no child about whom there are child protection concerns is discharged from hospital without a documented plan for the future care of the child. The plan must include follow-up arrangements. Hospital chief executives must introduce systems to monitor compliance with this recommendation. (paragraphs 9.101 and 10.146)
- 1 **Recommendation 72** No child about whom there are concerns about deliberate harm should be discharged from hospital back into the community without an identified GP. Responsibility for ensuring this happens rests with the hospital consultant under whose care the child has been admitted. (paragraph 9.105)
- 2 **Recommendation 73** When a child is admitted to hospital and deliberate harm is suspected, the doctor or nurse admitting the child must inquire about previous admissions to hospital. In the event of a positive response, information concerning the previous admissions must be obtained from the other hospitals. The consultant in charge of the case must review this information when making decisions about the child's future care and management. Hospital chief executives must introduce systems to ensure compliance with this recommendation. (paragraph 10.36)
- 1 **Recommendation 74** Any child admitted to hospital about whom there are concerns about deliberate harm must receive a full and fully-documented physical examination within 24 hours of their admission, except when doing so would, in the opinion of the examining doctor, compromise the child's care or the child's physical and emotional well-being. (paragraph 10.41)

- 1 **Recommendation 75** In a case of possible deliberate harm to a child in hospital, when permission is required from the child's carer for the investigation of such possible deliberate harm, or for the treatment of a child's injuries, the permission must be sought by a doctor above the grade of senior house officer. (paragraph 10.73)
- 1 **Recommendation 76** When a child is admitted to hospital with concerns about deliberate harm, a clear decision must be taken as to which consultant is to be responsible for the child protection aspects of the child's care. The identity of that consultant must be clearly marked in the child's notes so that all those involved in the child's care are left in no doubt as to who is responsible for the case. (paragraph 10.105)
- 1 **Recommendation 77** All doctors involved in the care of a child about whom there are concerns about possible deliberate harm must provide social services with a written statement of the nature and extent of their concerns. If misunderstandings of medical diagnosis occur, these must be corrected at the earliest opportunity in writing. It is the responsibility of the doctor to ensure that his or her concerns are properly understood. (paragraph 10.162)
- 1 **Recommendation 78** Within a given location, health professionals should work from a single set of records for each child. (paragraph 11.39)
- 1 **Recommendation 79** During the course of a ward round, when assessing a child about whom there are concerns about deliberate harm, the doctor conducting the ward round should ensure that all available information is reviewed and taken account of before decisions on the future management of the child's case are taken. (paragraph 11.39)
- 1 **Recommendation 80** When a child for whom there are concerns about deliberate harm is admitted to hospital, a record must be made in the hospital notes of all face-to-face discussions (including medical and nursing 'handover') and telephone conversations relating to the care of the child, and of all decisions made during such conversations. In addition, a record must be made of who is responsible for carrying out any actions agreed during such conversations. (paragraph 11.39)
- 2 **Recommendation 81** Hospital chief executives must introduce systems to ensure that actions agreed in relation to the care of a child about whom there are concerns of deliberate harm are recorded, carried through and checked for completion. (paragraph 11.39)
- 2 **Recommendation 82** The Department of Health should examine the feasibility of bringing the care of children about whom there are concerns about deliberate harm within the framework of clinical governance. (paragraph 11.39)
- 2 **Recommendation 83** The investigation and management of a case of possible deliberate harm to a child must be approached in the same systematic and rigorous manner as would be appropriate to the investigation and management of any other potentially fatal disease. (paragraph 11.53)
- 3 **Recommendation 84** All designated and named doctors in child protection and all consultant paediatricians must be revalidated in the diagnosis and treatment of deliberate harm and in the multi-disciplinary aspects of a child protection investigation. (paragraph 11.53)

- 3 **Recommendation 85** The Department of Health should invite the Royal College of Paediatrics and Child Health to develop models of continuing education in the diagnosis and treatment of the deliberate harm of children, and in the multi-disciplinary aspects of a child protection investigation, to support the revalidation of doctors described in the preceding recommendation. (paragraph 11.53)
- 3 **Recommendation 86** The Department of Health should invite the Royal College of General Practitioners to explore the feasibility of extending the process of new child patient registration to include gathering information on wider social and developmental issues likely to affect the welfare of the child, for example their living conditions and their school attendance. (paragraph 12.29)
- 3 **Recommendation 87** The Department of Health should seek to ensure that all GPs receive training in the recognition of deliberate harm to children, and in the multi-disciplinary aspects of a child protection investigation, as part of their initial vocational training in general practice, and at regular intervals of no less than three years thereafter. (paragraph 12.29)
- 3 **Recommendation 88** The Department of Health should examine the feasibility of introducing training in the recognition of deliberate harm to children as part of the professional education of all general practice staff and for all those working in primary healthcare services for whom contact with children is a regular feature of their work. (paragraph 12.29)
- 2 **Recommendation 89** All GPs must devise and maintain procedures to ensure that they, and all members of their practice staff, are aware of whom to contact in the local health agencies, social services and the police in the event of child protection concerns in relation to any of their patients. (paragraph 12.29)
- 2 **Recommendation 90** Liaison between hospitals and community health services plays an important part in protecting children from deliberate harm. The Department of Health must ensure that those working in such liaison roles receive child protection training. Compliance with child protection policies and procedures must be subject to regular audit by primary care trusts. (paragraph 12.57)

Police recommendations

- 1 **Recommendation 91** Save in exceptional circumstances, no child is to be taken into police protection until he or she has been seen and an assessment of his or her circumstances has been undertaken. (paragraph 13.17)
- 1 **Recommendation 92** Chief constables must ensure that crimes involving a child victim are dealt with promptly and efficiently, and to the same standard as equivalent crimes against adults. (paragraph 13.24)
- 1 **Recommendation 93** Whenever a joint investigation by police and social services is required into possible injury or harm to a child, a manager from each agency should always be involved at the referral stage, and in any further strategy discussion. (paragraph 13.52)
- 1 **Recommendation 94** In cases of serious crime against children, supervisory officers must, from the beginning, take an active role in ensuring that a proper investigation is carried out. (paragraph 13.55)

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do so is to run the risk that the jury may be influenced by their knowledge or belief that some of the issues of fact have been canvassed in front of the judge and that he has formed a particular view as to where the truth lies: *Mitchell v. R.* [1998] A.C. 695, P.C.

The following "exceptions" should not be taken to be exhaustive. Statutory provisions apart, they are merely a list of situations where the courts have accepted that it may be appropriate to hear evidence in the absence of the jury.

B. EXCEPTIONS

(1) Determining competence of witness

4-288 See the *Youth Justice and Criminal Evidence Act 1999*, s. 74(1), *post*, § 8-16b.

(2) Determining admissibility of defendant's previous plea of guilty

4-289 There is a conflict of authority. In *R. v. Rimmer*, 56 Cr.App.R. 196, C.A. it was said that the circumstances of the earlier plea of guilty should be investigated in a trial-within-a-trial. In *R. v. Hetherington* [1972] Crim.L.R. 703, however, the Court of Appeal was unable to accept as applicable to all cases the observation in *Rimmer* that the question of admissibility should be determined in a trial-within-a-trial. As to the admissibility of an earlier plea of guilty, see *post*, § 15-442.

(3) Determining admissibility of tape recordings

4-290 Tape recordings are admissible as evidence provided that they are shown to be both original and authentic. Copies are inadmissible in the absence of: (a) proper explanation as to why the originals are not available, and (b) proof of the complete accuracy of the copies: *R. v. Robson and Harris* [1972] 1 W.L.R. 651, CCC (Shaw J.), where the prosecution sought to tender in evidence tape recordings of alleged conversations between the defendants and a prosecution witness. The evidence and argument on the question of the admissibility of the tapes was heard in the absence of the jury. Shaw J. held that in considering the question of admissibility the court is required to do no more than satisfy itself that what the prosecution alleges to be original tapes are shown, *prima facie*, to be original by evidence which defines and describes the provenance and history of the recordings up to the moment of production in court. If that evidence appears to remain intact after cross-examination it is not incumbent on the judge to hear and weigh other evidence which might controvert the *prima facie* case. To embark on such an inquiry is to trespass on the ultimate function of the jury. Shaw J.'s ruling was upheld by the Court of Appeal (unreported). Ordinarily the larger issue of authenticity is manifestly a matter for the jury's consideration on admissible evidence. See also *R. v. Ali and Hussain* [1966] 1 Q.B. 688, 49 Cr.App.R. 230, C.C.A. in which it was acknowledged that issues of weight and admissibility may overlay each other, and *R. v. Stevenson*, 55 Cr.App.R. 171, Assizes (Kilner Brown J.).

(4) Miscellaneous

4-291 The issue also arises in respect of the admissibility of confessions (*post*, §§ 15-380 *et seq.*), the admissibility of identification evidence (*post*, § 14-35), the admissibility of *res gestae* statements (*post*, §§ 11-74 *et seq.*), questioning by the judge of a hostile or unwilling witness (*post*, §§ 8-94a, 28-122), and whether the jury should be directed that they may draw inferences against a defendant who fails to give evidence (*post*, § 4-305a).

In *R. v. Wright*, *The Times*, May 31, 2000, C.A. it was said that where the prosecution seek to cross-examine as to bad character on matters other than criminal convictions, and where the significance to be attached to such matters is in issue, it would be better if the relevant evidence is presented on the *voir dire* before the decision is taken as to whether the matter may go before the jury.

VII. SUBMISSION OF INSUFFICIENT EVIDENCE

A. PRACTICE

4-292 Submissions of no case are made at the close of the case for the prosecution (save for

influenced by their knowledge or belief that said in front of the judge and that he has duties: *Mitchell v. R.* [1998] A.C. 695, PC, taken to be exhaustive. Statutory provisions re the courts have accepted that it may be of the jury.

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petence of witness

see *loc. cit.* [1999] 3 W.L.R. 988, *post.* §§ 8-36b.

defendant's previous plea of guilty

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provided that they are shown to be both in the absence of: (a) proper explanation of proof of the complete accuracy of the R. 651, CCC (Shaw J.), where the prosecution of alleged conversations between witness and argument on the question of absence of the jury. Shaw J. held that court is required to do no more than original tapes are shown, prima facie, scribes the provenance and history of in court. If that evidence appears to prima facie case. To embark on such of the jury. Shaw J.'s ruling was upheld of the larger issue of authenticity is in admissible evidence. See also *R. v. App.R.* 230, CCA, in which it was ity may overlay each other, and *R. v. (Shaw J.).*

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ity of confessions (*post.*, §§ 15-380 *et post.*, § 14-35), the admissibility of *res* by the judge of a hostile or unwilling jury should be directed that they to give evidence (*post.*, § 4-305a).

It was said that where the prosecution matters other than criminal conviction such matters is in issue, it would be *in dicto* before the decision is taken

IENT EVIDENCE

in case for the prosecution (save for

the exceptional case created by the *Domestic Violence, Crime and Victims Act 2004*, *see* *post.*, §§ 4-298, 19-1180). Attempts have occasionally been made to renew such a submission during the course of the defence case. The Court of Appeal has said that whilst such a submission ought normally to be made at the close of the prosecution case, it may be made at the end of the defence case: *R. v. Anderson, The Independent (UK)*, July 13, 1998. Similarly, in *R. v. Ramsey* [2000] 5 *Archbold News* 3, CA, it was said that where, in a borderline case, the judge properly rules that there is a case to answer, he may be under a duty to re-visit the issue at the end of the evidence, taking account of the evidence called on behalf of the defence. In *R. v. Brown (Darius)* [2002] 1 Cr.App.R. 5, CA, reference having been made to these authorities and to other unreported decisions, it was confirmed that if, at any time after the conclusion of the prosecution case, the judge is satisfied that no jury, if properly directed, could convict, he has the power to withdraw the case from the jury, but that this is a power to be sparingly exercised. It is submitted that it would not be a proper exercise of this power for the trial judge to purport to assess the credibility of any evidence adduced on behalf of a defendant, thereby usurping the function of the jury.

Submissions of no case should be made in the absence of the jury: *R. v. Fulmerthorpe*, 58 Cr.App.R. 348, CA. One possible qualification to this principle is if the defence ask that the jury remain, in which case the judge should hear submissions in the absence of the jury as to why there should be a departure from normal procedure: *Crosdale v. R.* [1995] 2 All E.R. 500, PC. It is difficult to envisage a legitimate reason; an attempt by the defence to make an extra speech would not provide such a reason: *ibid.*

If the submission of no case is rejected, there should be no comment to the jury: *R. v. Smith and Doe*, 85 Cr.App.R. 197, CA. However, it being generally desirable, and especially so in long cases, that the judge keeps the jury informed as to what is happening, it is proper for him to give a brief explanation for upholding one or more submissions of no case, so long as he says nothing which might be construed as indicating a belief on his part that any remaining counts are well-founded: *R. v. Thurunazhokkarasu* [1998] 7 *Archbold News* 3, CA (97 03289 Y5).

As to whether the trial judge is obliged, or even entitled to stop a case where he is of the opinion (subject to inviting and considering submissions) that no prima facie case has been made out, but where no contention to that effect has been put forward by the defence advocate, see *post.*, § 7-79.

See *post.*, § 4-303, as to the right of a jury to acquit at any time after the close of the prosecution case.

B. PRINCIPLE

A submission of no case should be allowed when there is no evidence upon which, if 4-293 the evidence adduced were accepted, a reasonable jury, properly directed, could convict. In such a case, a directed verdict must be taken from the jury.

C. R. v. GALBRAITH

In *R. v. Galbraith*, 73 Cr.App.R. 124, CA, the earlier authorities were reviewed and 4-294 guidance given as to the proper approach:

"(1) If there is no evidence that the crime alleged has been committed by the defendant there is no difficulty—the judge will stop the case. (2) The difficulty arises where there is some evidence but it is of a tenuous character, for example, because of inherent weakness or vagueness or because it is inconsistent with other evidence. (3) Where the judge concludes that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict on it, it is his duty, on a submission being made, to stop the case. (4) Where however the prosecution evidence is such that its strength or weakness depends on the view to be taken of a witness's reliability, or other matters which are generally speaking within the province of the jury and where on one possible view of the facts there is evidence on which the jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury" (*per* Lord Lane C.J. at p. 127).

The Lord Chief Justice then observed that borderline cases could be left to the discretion of the judge. For an example of the approach of the Court of Appeal to the exercise of this discretion, see *R. v. Leley* [1996] 1 Cr.App.R. 39, CA.

4-295 In *R. v. Shippey* [1988] Crim.L.R. 767, Crown Court (a decision on its facts, laying down no new principle of law; *R. v. Poyer, Sparkes and Walker*, unreported, April 7, 2004, CA [2004] EWCA Crim. 1163n, Turner J.) held that the requirement to take the prosecution evidence at its highest did not mean "picking out all the plums and leaving the duff behind". The judge should assess the evidence and if the evidence of the witness upon whom the prosecution case depended was self-contradictory and out of reason and all common sense then such evidence was tenuous and suffered from inherent weakness. His Lordship did not interpret *Galbraith* as meaning that if there are parts of the evidence which go to support the charge then that is enough to leave the matter to the jury, no matter what the state of the rest of the evidence is. It was, he said, necessary to make an assessment of the evidence as a whole and it was not simply a matter of the credibility of individual witnesses or of evidential inconsistencies between witnesses, although those matters may play a subordinate role. In *Brooks v. DPP* [1994] 1 A.C. 768 at 781, PC, it was said (in the context of committal proceedings) that questions of credibility, except in the clearest of cases, do not normally result in a finding that there is no prima facie case.

As to the evidential value of the defendant's statements for the purposes of a submission of no case, see *post*, § 15-408; and for reliance upon a co-defendant's confession where there is a case for the co-defendant to answer and the co-defendant's guilt would be probative in the case against the defendant, see *R. v. Haster* [2005] 2 Cr.App.R. 3, HL., *post* § 9-85.

D. MAGISTRATES' COURTS

4-296 In their summary jurisdiction magistrates are judges both of facts and law. It is therefore submitted that even where at the close of the prosecution case, or later, there is some evidence which, if accepted, would entitle a reasonable tribunal to convict, they nevertheless have the same right as a jury to acquit if they do not accept the evidence, whether because it is conflicting, or has been contradicted or for any other reason.

4-297 It is submitted that in committal proceedings the question to be determined by the magistrates, in the event of a submission of no case being made, is the same question which a judge has to ask himself in like circumstances during a trial on indictment.

Magistrates are not obliged to give reasons for rejecting a submission of no case: *Harrison v. Department of Social Security* [1997] C.O.D. 220, DC.

E. PARTICULAR APPLICATIONS

Evidence equivocal as to which of two people, jointly indicted, committed the offence

4-298 If two people are jointly charged and the evidence does not point to one rather than the other, and there is no evidence that they were acting in concert, a verdict of not guilty is appropriate in the case of both: *R. v. Abbott* [1955] 2 Q.B. 497, 39 Cr.App.R. 141, CCA; *Collins and Fox v. Chief Constable of Merseyside* [1988] Crim.L.R. 247, DC (*post*, § 21-169); and *Swallow v. DPP* [1991] Crim.L.R. 610, DC.

The principle has been considered on a number of occasions in the context of acts of violence committed by one or both parents on a child in the home: see *R. v. Gibson and Gibson*, 80 Cr.App.R. 24, CA (convictions under section 20 of the *Offences against the Person Act* 1861 quashed, but court, *obiter*, expounded basis upon which prima facie case against each in respect of an offence contrary to section 1 of the *CPA* 1933 could have been founded); *R. v. Lane and Lane*, 82 Cr.App.R. 7, CA (manslaughter convictions quashed, no evidence to establish presence of either at time child injured, or participation); *R. v. Russell and Russell*, 85 Cr.App.R. 388, CA; *R. v. Board*, 85 Cr.App.R. 395, CA; *R. v. Asim and Mason*, 94 Cr.App.R. 180, CA; *R. v. Stoddcock and Merry*, 99 Cr.App.R. 326, CA (see further *post*, § 4-301a; and *post*, §§ 11-21, 11-29a). Where, however, the defendant is charged in the same proceedings with murder or manslaughter and also with an offence under section 5 of the *Domestic Violence, Crime and Victims Act* 2004 in respect of the same death, the question of whether there is a case to answer on the charge of murder or manslaughter is not to be

2005] 2 WLR

[2005] 2 WLR

D v East Berkshire Community Health NHS Trust (HL(E))

D23

House of Lords

D v East Berkshire Community Health NHS Trust and others

MAK and another v Dewsbury Healthcare NHS Trust and another

RK and another v Oldham NHS Trust and another

[2005] UKHL 23

2005 Jan 31;
Feb 1, 2;
April 21

Lord Bingham of Cornhill,
Lord Nicholls of Birkenhead, Lord Steyn,
Lord Rodger of Earlsferry and
Lord Brown of Eaton-under-Heywood

Negligence — Duty of care to whom? — Parents suspected of child abuse — Healthcare professionals and social workers mistakenly diagnosing and investigating child abuse by parents — Parents claiming damages for resulting psychiatric injury — Whether duty of care owed by healthcare professionals or social workers to parents

In each of three cases the parents of young children brought actions for negligence against healthcare authorities and, in one case a local authority, claiming damages for alleged psychiatric harm caused as a result of unfounded allegations made by healthcare and child care professionals, that the parents had abused their children. In each case the judge determined as a preliminary issue that no duty of care was owed to the parents by any of the defendants on the ground that it was not fair, just and reasonable to impose such a duty. The actions were dismissed and on the parents' appeals, which were heard together, the Court of Appeal affirmed the judges' rulings.

On appeal by the parents—

Held, dismissing the appeal (Lord Bingham of Cornhill dissenting), that public confidence in the child protection scheme could only be maintained if a proper balance was struck between the need to safeguard a child from parental abuse and the protection to be given to a parent from unnecessary interference in his family life; that the child, not the parent, was the doctor's patient in whose best interests he was obliged to act and although the interests of the parent and the child were normally coincident they were not so where the possibility of abuse arose; that where the doctor's suspicions were aroused he had to be able to act single-mindedly in the child's interests without regard to the possibility of a claim by the parent; that, given the seriousness of child abuse as a social problem, healthcare and other child care professionals should not be subject to conflicting duties when deciding whether a child might have been abused and what further steps should be taken; that potential disruption to the suspected parent's family life did not justify according him a higher level of protection than other suspects of crime, that the investigations should be conducted in good faith; and that, in the absence of sufficient proximity, it was accordingly, not fair, just and reasonable that the common law duty of care claimed by the parents should be imposed (post, paras 71-74, 77-78, 81, 85-86, 88-91, 95-96, 108-111, 115, 119, 129, 138).

Decision of the Court of Appeal [2003] EWCA Civ 1151; [2004] QB 558; [2004] 2 WLR 58; [2003] 4 All ER 796 affirmed.

The following cases are referred to in the opinions of their Lordships:

A (Children) (Conjoined Twins: Surgical Separation), *In re* [2001] Fam 147; [2001] 2 WLR 480; [2000] 4 All ER 961, CA

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GENERAL MEDICAL COUNCIL
PROFESSIONAL CONDUCT COMMITTEE

On:
Thursday 5 August 2004

Held at:
St James' Buildings
79 Oxford Street
Manchester M1 6FQ

Case of:

DAVID SOUTHALL MB BS 1971 Lond
(Day Eight)

Committee Members:
Professor D McDevitt (Chairman)
Ms F Bremner
Mr S Gurjar
Ms C Langridge
Rev J Philpott
Mr D Mason (Legal Assessor)

MR K COONAN QC, instructed by Messrs Hempsons, appeared on behalf of Professor Southall, who was present.

MR R TYSON, of Counsel, instructed by Messrs Field Fisher Waterhouse, appeared on behalf of the Council and the Complainant.

(Transcript of the shorthand notes of TranscribeUK
Tel No: 0208 614 5799)

A investigation by the Trust into the research side of the reason why he was suspended at that time, is that correct?. That is when you were brought in.

A There were, in fact, a series of investigations into his research work. I was only involved in evaluating those. There was a first, quick evaluation of his research, which was later shown to have been flawed, which was done for the Trust. There was the Government inquiry which, ostensibly, looked at all research in the north Staffordshire hospital, but was clearly acknowledged to have been motivated by concern expressed to various members of Parliament, about the C-nap(?) trial, which I have just been talking about, The Trust then undertook its own, detailed two year research of this, and also undertook two separate audits to check that, in actual fact, the consent documents all were in place. There was a police investigation, and you will be aware that the General Medical Council has also looked at complaints about that research twice, and they all ended up finding no grounds for taking further action, which goes along with the judgment that Sir Ian Chalmers and I made after our first four month investigation between April and August 2000. It was only after my involvement in doing that evaluation for them, I became personally acquainted with Professor Southall and his family.

THE CHAIRMAN: Thank you. There are no further questions. Do you have anything further, Mr Coonan?

D MR COONAN: No, thank you sir.

THE CHAIRMAN: Thank you very much.

(The witness withdrew)

E MR COONAN: May I call Dr Chipping.

PATRICIA MARGARET CHIPPING, Sworn

Examined by MR COONAN

F Q Dr Chipping, you have given evidence before the Committee at an earlier stage of the proceedings. The Committee will appreciate that, at an early stage in the developing facts and events in the case, you were, at one time, Acting Medical Director of the Trust, and then became Medical Director. Can you remind the Committee, please, when your full-time appointment as Medical Director was made?

A I took up my appointment as full-time Medical Director in June 2001.

G Q You gave evidence earlier about the reasons for Professor Southall's suspension.
A Yes.

Q You gave evidence about the causes of the investigations which have been carried out under the auspices of the Trust.

A Yes.

H

A Q You have described how that fell into three categories – research, personal conduct and child protection – is that right?

A That is correct.

Q On each of those three areas, following intensive investigation, Professor Southall was exonerated.

B A That is correct.

Q You are aware, since you gave evidence, of the findings of this Committee.

A Of course, yes.

Q I want to ask you about Professor Southall since his return to work in the latter part – I think it was August – 2001.

C A October 2001.

Q When the suspension was lifted.

A When the suspension was lifted. You will understand, from some of the discussion we have heard this afternoon, that there was a period of coming to terms with the effects of the suspension, and an opportunity to pick up the reins of general paediatrics. We actually arranged an attachment at another trust to enable Professor Southall to regain his clinical confidence. He has returned to work very specifically in the areas of general paediatrics, with his particular interest in respiratory medicine. He has not been undertaking child protection since that time.

D

Q You mentioned him going under the auspices of another trust. Do I take it, therefore, that he has come back to your Trust at some stage during the previous nearly three years now?

E A Yes, he returned to work in our Trust, I think it would be February 2002.

Q The Committee may be interested to learn a number of things. First of all, in your judgment and, as far as you know, the judgment of other senior colleagues, how has he performed in the field of general paediatrics?

F A All of the indications that I have (and this is confirmed by discussion with colleagues throughout the child health directorate) is that his opinion is highly valued. He is an extremely competent general paediatrician, and that has been brought home to me repeatedly. I should also add that not only has he taken up those reins, but he had done so with enthusiasm and with extreme hard work, and taken on some additional responsibilities for a colleague who is on long-term sick leave.

G Q To what extent is the general paediatric service in your Trust being delivered now?

A We have a limited number of consultants who do the general paediatric work. The way that it is organised is that the general paediatricians act as consultant of the week, which is caring for all of the children on the acute paediatric wards, for that week, although the night time on call is done on a separate general paediatric rota. We have about eight paediatricians on that rota. We are actually one down at the moment because of maternity leave, and the individual leaving the Trust, so the rota is perhaps a little more onerous than I would like it to be, at the moment.

H

A

Q You said that he had not carried out any child protection work.

A No.

Q You spoke last time about the category 1 and category 2 types of work.

A Yes.

B

Q Let us look at that a little more closely. During the time he has gone back to work, have you had any complaints about his conduct from anybody?

A No.

Q So far the category 1 work is concerned – I put this as a general question – during work as a general paediatrician, it might arise that a child appears with bruising or with a fracture and so on, which might raise a question of non-accidental injury.

C

A Yes, indeed – I think that is almost inevitable in paediatric practice.

Q Do you have any arrangement within the Trust to deal with that issue, first of all, generally and, secondly, more particularly, so far as Professor Southall's involvement in child protection issues is concerned?

D

A Yes. Generally, we run four on-call rotas for paediatrics. Paediatric intensive care and neonatal intensive care are self-explanatory. General paediatrics is virtually everything else. Child protection is a rota that runs with a separate set of doctors, most of whom have a community paediatrician background, and have specific training in child protection. That rota runs alongside, and provides a twenty-four hour a day, seven day a week, three hundred and sixty-five days a year, separate paediatric cover for child protection. That of course covers the whole of the Trust, because you will appreciate that a child might present just as easily through accident and emergency, as it might to a paediatrician on the ward, so that rota is a Trust-wide rota.

E

Q So far as Professor Southall is concerned, has that structure effectively prevented him from doing what may be called, generically, child protection work?

A Yes. What has happened is that if Professor Southall has concerns that this might be a child who has been abused, he is clearly instructed to contact the Trust child protection doctor on call at that time. I have in fact spoken just yesterday with the Trust's child protection doctor, who happens, also, to be the head of division for women and children, which is just slightly above the clinical director. This individual confirmed that there is a very robust system at work, and that appropriate referrals have been received. She is confident, as I am, that this system has worked robustly.

F

Q Are there any breaches by Professor Southall?

G

A No.

Q I think you may have heard some observations this morning by Mr Tyson about sanctions.

A Yes.

H

Q I want to take you, please, to this question of Professor Southall and the imposition of conditions on practice.

A A Yes.

Q I am not going to ask you to usurp the jurisdiction of the Committee, but what I am going to ask you is whether or not, subject to appropriate wording, a system of the imposition of conditions, from the view of the Trust, with you wearing the Trust hat for these purposes, is workable and capable of being policed.

B A We have, effectively, had the system in place for two years. I am confident that it has worked and, therefore, I believe the Trust could reassure the Committee that it could work.

Q I go so far as to ask you this, and answer, if you are able, wearing the Trust hat: would you like to see that work?

A Yes.

C MR COONAN: Thank you.

Cross-examined by MR TYSON

D Q Just dealing with some of those last answers, the assurances that you seek to give the Committee would of course only apply to category 1, would it not? You could not control, or police, any category 2 work coming from outside, as it were – private work to the doctor.

A That would be more difficult. It would of course be possible to insist that no such work was taken on and, certainly, to my knowledge, at the present time, no new work has been taken on in the last two and a half years since Professor Southall has been back at work.

E Q But as his employer, surely, you could only insist it was not taken on during Trust time. What he did out of Trust time, in terms of private work and medical reports, you could not control.

F A It is obviously more difficult – there is no doubt about that. On the other hand, I believe that the Trust now has a very robust working arrangement with Professor Southall, and if a requirement of the Committee was that, in some way, that was a condition of any form of limitation on practice, then, as Medical Director of the Trust, I would wish to work with the General Medical Council to ensure that that was happening. The reason that I would be so keen to do that is because I do not wish to lose Professor Southall's very considerable contribution to general paediatric work within the Trust.

G Q I understand that, and I also recall the evidence you gave in relation to previous matters. Lastly, one of the character witnesses, whose letter was read out to us earlier, was Professor Anderson, and I think you were in the room before lunch when that was read.

A Yes.

H Q He included in his letter, this comment, which we have on our page 7, in the last paragraph, where he was describing the personality of the doctor, and perhaps you would like to look at this. The last paragraph begins with these lines:

A

“All of this previous experience shows that David is unprepared to view things as a spectator if he considers that certain aspects have failed to receive the attention that they deserve.”

That is the nature of the beast, is it not, Dr Chipping?

B

A It is a very interesting point. I think that one has to agree with Professor Anderson. The extraordinary thing is that that appears to be the nature of the beast when one looks particularly at child protection work. It is not really when one comes to look at general paediatrics. In fact, Professor Southall's determination to arrive at an appropriate diagnosis appears, when he tackles general paediatric work, to result in very thorough, well thought through and detailed diagnostic work. In one sense, it is the nature of the beast, but it could also be, and would appear in his general work, as far as I am able to comment, bearing in mind I am not a paediatrician, to be a strength rather than a weakness.

C

Q The fear which I have to put to you is that if Professor Southall feels strongly about anything, he will go and do it. That is his past and, in many ways, one of his strengths, which has been commented upon.

D

A It is – I have to say that it is a strength or a weakness which, as a Trust, we have addressed with Professor Southall. I have always recognised (and I recognised at the time that suspension was lifted) that if Professor Southall was going to return successfully to practice within the National Health Service, within the Trust, it was an issue we had to address, and we have done so both together and with external assistance. I believe that... I am not saying leopards change their spots, but I do think there is some learned behaviour that actually has occurred, and I have been most impressed by the diligence and the care by which Professor Southall has taken his rehabilitation into the Trust. It is clear to me that however painful it would be (and it would be) for Professor Southall's registration to be restricted so that he was not able to undertake child protection work, I believe that he does understand that if he were to, in any way, breach a condition that was placed on him by this Committee, that I will be the first person that reported him back to the General Medical Council.

E

F

Q Can we agree this far: there must be a risk, bearing in mind his forceful nature and personality, that some bureaucratic restraint would be ignored if he felt strongly that the ultimate object was more important.

A Yes, it is a risk. Do I think it is a significant risk – no I do not, and the reason I do not think it is a significant risk is because we have successfully worked with this system for the last two and a half years to, I believe, the considerable benefit of the children of North Staffordshire and beyond.

G

Q You say you can restrict, as it were, his clinical work, whilst he is an employee, to general paediatrics, do you have any control over the nature or extent of his research work?

A I do not, but Professor Southall is not currently undertaking any research and, indeed, his contract, or his funding stream at Keele, has changed, such that he is supported by postgraduate education monies not research monies.

H

A Q But you would have no control over that aspect – it is a Keele University matter, as it were.

A Yes and no – except that we work in extreme collaboration with the University of Keele in research matters, and I would be confident that if there was research where there was the slightest concern, the research governance structures that are now in place in North Staffordshire are probably one of the most rigorous in the country.

B MR TYSON: Thank you very much. I have no further questions.

Questioned by THE COMMITTEE

MS LANGRIDGE: Dr Chipping, I do not think you have seen this bundle, but we have some 142 pages of references.

C A Yes.

Q And testimonials from a wide variety of paediatricians and other doctors.

A Yes.

D Q One of the themes that runs through some of the correspondence is that if Professor Southall were to cease doing child protection work, it would be a blow to other paediatricians, in a situation where, already, there are very few doctors who are willing to take up child protection. This would act as a disincentive to the profession, and I wondered if you would comment, because it is by no means clear to me, (although it is for the Committee to make the decision, and I understand that) exactly what you are saying. Are you saying that, in your opinion, Professor Southall should not do child protection work?

E A I think the ... it is not up to me of course to do this Committee's work for it, but in discussion with Mr Coonan, and I have heard the discussion today about the potential sanctions, I do think that the General Medical Council – the Committee here – is in an extremely difficult situation. It is clear to me that there was ... that the matters on which you found are very serious, and the argument, as I understood it from Mr Tyson this morning, was that it would not be possible for the Committee to reach a judgment which, if you like, was of restricting practice. What I am saying is, if that were the outcome of the Committee (and, as I say, I have my personal views but it would be inappropriate to express them), I believe that, as a Trust, we could make that work.

F Q Does it therefore follow that if no restrictions are placed on Professor Southall's practice, in terms of the type of work that he could do, you could also make that work?

G A If he were to return to practice... I am not actually sure there would be very much difference if he were to return to unrestricted practice, because ... the effect of the question that has been asked about counsel instructing, I think probably the chances of Professor Southall doing a lot of category 2 work in respect of child protection is vanishingly small. In terms of work within the Trust, I would probably wish, as the Medical Director of the Trust, to retain the present working practice we have anyway.

H

A THE CHAIRMAN: The present arrangement that you described to us is where Professor Southall works in general paediatrics, and does not involve himself in child abuse type work – child protection work – and also does not ITU work.

B A Let me just clarify – the not doing ITU work was by mutual agreement because, I think you will appreciate, paediatric intensive care unit work is extremely onerous. There was nothing at all about my lack of confidence in Professor Southall that would have restricted his access to PICU work. It was by mutual agreement.

B Q The other side of it – was that by mutual agreement, or was that because of conditions imposed by the Trust?

C A That was because of conditions imposed by the Trust because I believe, as the Trust Medical Director, that although the report that was described to you earlier found no matters of substance with regard to the Professor's child protection work, it was very clear to me that there were a number of inquiries ongoing with the General Medical Council. I did not believe it would be appropriate for Professor Southall to return to child protection practice whilst those were ongoing. In terms of the rest of the work that was done, we worked together to decide on exactly how we would manage the return to work process and, from the Trust's perspective, it has worked very well indeed.

D Q In terms of getting this working arrangement with Professor Southall, was that an easy thing to do or difficult?

E A It was very straightforward. I suppose one of the... I have to say that I think Professor Southall and I have developed a close understanding, shall we say, and a mutual respect, actually. He has recognised that maybe a trust medical director is somebody of wisdom, and I do regard my role as Trust Medical Director to protect doctors from themselves. Professor Southall is not the first person I have done that for. It is important, and I suppose the Committee might have some concern, therefore, would any sort of arrangement that was put in place work if I was not the Trust Medical Director, and I think that is something you would have to think through. I am not planning to step down immediately. It was not a difficult thing to put in place. Professor Southall understands my concerns, and I think has also been advised by his legal team that this is an appropriate way to move forward. It certainly was the case on return from suspension. There was no difficulty in getting this arrangement into place, and I have to say that Professor Southall had been most careful to keep me informed if there were any matters of concern as regards child protection whatsoever.

G Q One of the things that Mr Tyson has emphasised this morning (and you have probably heard it) is that one of Professor Southall's problems appears to be his lack of insight, and lack of insight perhaps in relation to this particular area. Based on the fact that you have had this ongoing working relationship with him while things have changed, do you have any comment about his insight? Do you feel he has more insight now into this side of his work than he had previously, or would you subscribe to the fact that he does not have any insight?

H A No, I would not subscribe to the fact that he does not have any insight. I think he has good insight, but I think he is a man who does not change his mind easily, and I think that is a slightly different thing. One of the things that I am sure will have come out in the testimonials is that Professor Southall is actually a man of great principle.

A He will not change his mind if he does not think his mind should be changed. Does he have an insight into the impact he has on others – I think he probably has a better insight than he did earlier in his career, yes.

Q Lastly, if there was a system of conditions in place, even though it could be argued that you could not police things that were happening outside his NHS working hours, presumably, issues like this would be likely to come to your attention.

B A I would have thought they would be the first thing to come to my attention, yes.

Q Either through the local processes or by other means.

A They would certainly come to my attention through local processes, because I actually hold the child protection lead as the Director, with responsibility to child protection for the Trust so, in that respect, they would come to me officially. I actually have that lead director role, so that any communication through the chief executive with regard to child protection matters comes to me anyway. What would not necessarily come to my attention was if the request was from a remote area... remote from North Staffordshire. In other words, if Professor Southall were engaged in a child protection case in a different area, that would not come to my attention unless it was made very specific that should such an approach be made, it would have to be reported to me. I have no doubt that if that were a condition, then it would be reported to me. I am also aware that when we stopped Professor Southall from taking on new child protection cases before he was suspended, he did bring to my attention those cases where he was involved. Therefore, I do not have a difficulty in believing that that would happen. I believe it would and could happen.

C

D

Q Presumably, a global restriction on being involved in child protection would cover all aspects of it, be they category 1, category 2, or any other category people could think of.

E A Absolutely – if that was what the Committee decided, indeed, it would have to apply right across the board, if that is what the Committee felt should happen, yes.

Q It is clear we have not made any judgment; I am just trying to explore the facility of any possible findings we might make, and you clearly have expertise in this area.

F A I appreciate that, but it would have to cover NHS and all medico-legal work, yes.

THE CHAIRMAN: I have no other questions.

Further cross-examined by MR TYSON

G

Q You indicated that one of the reasons why conditions may be able to work is because of the relationship that has developed between you and Professor Southall.

A Yes.

Q Of course no condition can be made, can it, that he should continue working for his current Trust? He could resign and move to any other trust at any other time.

H

A A He could – he would not be able do so without a reference from his present employer, and a reference from his present employer would need to make very clear the condition that was imposed not by the Trust, but by the General Medical Council.

MR TYSON: Thank you.

Re-examined by MR COONAN

B Q Dr Chipping, arising out of the discussion, and focusing on the question of policing, there may be policing by the Trust itself; there may be policing by, as you put it, local processes. To what extent, to your knowledge, is the vigilant group, as it were, still out there monitoring or policing Professor Southall?

C A They are out there. There is still a very active lobby of opinion around Professor Southall, and the Trust is regularly contacted by that group.

Q Still focusing on the underlying proposition, the Committee of course is primarily concerned with protecting patients.

A Yes.

D Q I want you to focus on that need for the moment, and also the point that you have raised about protecting Professor Southall from himself. Can you take those two points together.

A Yes.

Q To what extent, in your opinion – again not trespassing on the Committee’s function – is any proposal for the imposition of conditions going to satisfy those twin principles?

E A As we have explored, the complaints around Professor Southall have centered on his research, which he is not currently undertaking, and child protection work, which is the business of this Committee now. In terms of protecting in the event of child protection work, then I believe this can be made to work. I believe we would have Professor Southall’s co-operation, and we would work closely in line with whatever the General Medical Council imposed, to make sure that we could police this. Would it protect Professor Southall from himself – sadly, I have to say, yes, I think it would, because I think it is in the area of child protection where Professor Southall has a particularly passionate belief based, quite understandably, on some of the work that he has seen. I can understand why he is so passionate about the issue of child protection, but I do have to say I believe that the imposition of this particular sanction will be extremely painful for Professor Southall – I do know that. Equally, it would have support from me, as Medical Director of the Trust, and I hope I have already made that clear.

MR COONAN: Thank you very much.

THE CHAIRMAN: Dr Chipping, thank you for coming a second time to help us in our deliberations.

H *(The witness withdrew)*